

NORTHWEST ORTHOPAEDIC ASSOCIATES, Ltd.
PATIENT INFORMATION
ALL INFORMATION MUST BE COMPLETE AND CURRENT

PLEASE PRINT

Date	Dr.	Referred by
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A. PATIENT INFORMATION

Patient First Name	M.I.	Last Name
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Street Address	Apt#	Home Phone Number
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City	State	Zip	Work Phone Number
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Social Security Number	Marital Status (Circle one) M S D W
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Age	Birth Date	Birth Place	_____ Male	_____ Female
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Name of Responsible Party	Address (If different than patient's)
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Name of Relative/Friend (in case we are unable to reach you)	Phone number
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Date Problem Began	_____ Working injury ___ Auto Accident ___ Other
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Are you able to work? Y N	Last day worked
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Primary Physician	Address	Phone Number
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If student, name of school	Contact Person
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City	State	Zip	Phone number
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B. EMPLOYER INFORMATION (If patient is a minor, parent's employment)

Employer	Employer of the insured
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Employer Street Address	Phone number ()
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City	State	Zip Code
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Only if your injury is work related will you need to complete the following information
Bill is to be sent to:

Name	Workman's Comp. Claim Number
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Street Address	Phone Number ()
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City	State	Zip Code
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PLEASE COMPLETE SECTIONS C AND D

C. INSURANCE

Primary Insurance Co.	Street Address
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City	State	Zip Code	___Male ___Female
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Policy #	Group #
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Policy Holder's Name	Policy Holder's SS#
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Secondary Insurance	Street Address
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Policy#	Group #
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Policy Holder's Name	Policy Holder's SS#
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D. AUTHORIZATION

I hereby authorize the release of information which said insurance company may request concerning treatment for myself or my dependents. I hereby assign NORTHWEST ORTHOPAEDICS the medical and/or surgical benefits to which I or my dependents are entitled to under my health insurance plan.

It is understood that this authorization does not relieve me from responsibility for charges incurred, and any balance not paid by my insurance company, for whatever reason, shall be paid by me upon receipt of billing accordingly.

_____	_____
Patient Signature	Date

The following signature authorizes the release of information stated above and for treatment, if the patient is a minor.

_____	_____
Signature Parent/Guardian	Date

I do ___ do not ___ specifically consent to transmission of my medical records via a facsimile (fax) machine.

_____	_____
Signature	Date

OPTIONAL

I recognize that the information disclosed may contain drug/alcohol or mental health information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____	_____
Signature	Date

I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV/AIDS testing information. I specifically consent to disclosure of such information.

_____	_____
Signature	Date