Name:

Chart:

Date:

PATIENT INFORMATION & DISCLOSURE FORM

Patient's Last Name _____ First _____ Middle _____ Sex _____

Home Address _____ City _____ State _____ Zip _____

Patient's Social Security No. _____ Cell Phone _____ Home Phone _____ Work Phone _____

Age _____ Birth date _____ Single _____ Married _____ Divorced _____ Widowed _____

Patient's Employer _____ Year with Firm _____ Occupation _____

Spouse's Name _____ Employer _____ Work Phone _____

Spouse's Social Security No. _____ Date of Birth _____ Occupation _____

Father's Name (IF MINOR) _____ Employer _____ Work Phone _____

Father's Social Security No. _____ Date of Birth _____ Occupation _____

Mother's Name (IF MINOR) _____ Employer _____ Work Phone _____

Mother's Social Security No. _____ Date of Birth _____ Occupation _____

Nearest Relative _____ Relationship _____ Phone _____

Family Physician _____ Referred by _____

Notify In Case of Emergency _____ Phone _____

Email address _____

INSURANCE INFORMATION

Date of injury or date of onset of symptoms _____

Place injury occurred: _____Home _____School _____Work _____Auto _____Other

PRIMARY INSURANCE COMPANY NAME _____

Insurance Co. Address _____ Phone _____

Subscriber's Name _____

Patient Relationship to Subscriber. Circle one (self, spouse, child) Subscriber Date of Birth _____

I.D. No. _____ Group No. _____

SECONDARY INSURANCE COMPANY NAME _____

Insurance Co. Address _____ Phone _____

Subscriber's Name _____

Patient Relationship to Subscriber. Circle one (self, spouse, child) Subscriber Date of Birth _____

INFORMATION RELEASE

I hereby authorize Summit Orthopaedics to release any information acquired in the course of my examination or treatment to the insurance carriers. I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to Summit Orthopaedics.

CONSENT TO TREAT: I consent to treatment at Summit Orthopaedics for services or supplies that have been or may be ordered by the physician. I understand that treatment may include but is not limited to: radiological examinations, injections, laboratory procedures, physical therapy, nursing care or medical and surgical treatment.

Please Read & Sign Below.
Recognized the inherent risks of transmission of contagious disease, especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc. where deemed necessary by physician. Questions should be discussed with your physician.

I AUTHORIZE SUMMIT ORTHOPAEDICS TO RECEIVE ASSIGNMENT OF INSURANCE PAYMENTS. IF THE CUSTOMARY CHARGES ARE MORE THAN THE BENEFITS ALLOWED UNDER RESPONSIBLE PARTY'S INSURANCE PLAN. I AGREE TO PAY THE DIFFERENCE. I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE I AM RESPONSIBLE FOR ALL CHARGES AND PAYMENTS.

I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files and authorize the insurance company to accept the photocopy.

I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

OWNERSHIP DISCLOSURE: Please note that the physicians of Summit Orthopaedics, L.L.C. have individual ownership interests in Mountain View Hospital and that they may refer you for services at Mountain View Hospital. If you would prefer to receive care or testing at another hospital or facility, please discuss this with your treating physician so that he or she may determine if that is possible.

RESPONSIBLE PARTY'S SIGNATURE **DATE**