# Patient Profile

**Doctor** ____________________

## *PATIENT INFORMATION*

**Name:** ____________________

**Address:** ____________________

____________________

**City,State** ____________________

**Phone:** ____________________ [ ]Home [ ]Work [ ]Other

**Phone:** ____________________ [ ]Home [ ]Work [ ]Other

**Patient ID #:** ____________________ **Sex** [ ]M [ ]F

**Date of Birth:** ____________________

**Social Security #:** ____________________

**Marital Status:** [ ]Married [ ]Single [ ]Divorced

**Referring Physican:** ____________________

**Primary Physician:** ____________________

### *PATIENT EMPLOYMENT*

**[ ]Employed [ ]Retired [ ]Unemployed [X]Other**

**Phone:** ____________________

**Employer:** ____________________

### *ALTERNATE*

____________________

____________________

____________________

### *GUARANTOR*

**[ ]Same as Patient**

**Name:** ____________________

**Address** ____________________

____________________

**City,State:** ____________________

### *EMPLOYMENT*

**Employer:** ____________________

**Phone:** ____________________

**Phone:** ____________________

**Social Security #:** ____________________

**Date of Birth:** ____________________

### *PRIMARY INSURANCE*

**[ ]Same as Patient [ ]Same as Guarantor [ ]Other**

**Insured Party:** ____________________

**Insured Phone:** ____________________

**Company:** ____________________

### *DATE OF INJURY :*

**Relationship to Patient:** ____________________

**Social Security #:** ____________________

**Insured ID:** ____________________

**Policy Group:** ____________________

**Date of Birth:** ____________________

### *SECONDARY INSURANCE*

**[ ]Same as Patient [ ]Same as Guarantor [ ]Other**

**Insured Party:** ____________________

**Insured Phone:** ____________________

**Company:** ____________________

**Relationship to** ____________________

**Social Security #:** ____________________

**Insured ID:** ____________________

**Policy Group:** ____________________

**Date of Birth:** ____________________

## MEDICARE SIGNATURE ON FILE

I request that payment of the authorized Medicare benefits be made on my behalf to **South County Orthopedic Specialists** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item ) of the HCFA-1500 form, or elsewhere on other charges approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ________________________ __________
Patient's Name (Please Print) Patient's Signature Date

## MEDIGAP ASSIGNMENT OF BENEFITS

I request that payment authorized Medigap benefits' be made either to me or on my behalf to South County Orthopedic Specialists for any services furnished by the listed provider/supplier. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits payable for related services.

______________________________ ________________________ __________
Patient's Name (Please Print) Patient's Signature Date

## PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed facility. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to pay the listed provider assignee. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

Payment in full is required at the time of service, for your convenience, we accept personal checks, Visa/MasterCard, as well as cash. Any insurance coverage which you may have is intended to protect you against financial loss, not as payment in full for your care. Payment in full for your care is your responsibility and may not be postponed until the time your insurance reimburses you. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

**Treatment Authorization**: I authorize the treatment by **South County Orthopedic Specialist**. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or liability of another party. I will make sure that my claims are paid promptly.

______________________________ ________________________ __________
Patient's Name (Please Print) Patient's Signature Date

## TREATMENT OF A MINOR

I authorize **South County Orthopedic Specialists** to treat a minor.

_______________________________________________ (minor)

______________________________ ________________________
Signature of Parent/Guardian Date