DATE ______________________

NPO NPR FU DOCTOR ______________________

PATIENT'S NAME ______________________

PATIENT'S ADDRESS ______________________

CITY ______________ STATE ______________ ZIP CODE ______________

PHONE # ______________ DATE OF BIRTH ______________

CELL # ______________ E-MAIL ADDRESS ______________

SOCIAL SECURITY # ______________ SEX M F

PATIENT'S EMPLOYER ______________________

EMPLOYER'S PHONE # ______________________

IF MARRIED, SPOUSE'S NAME ______________________

SPOUSE'S EMPLOYER ______________________

EMPLOYER'S PHONE # ______________________

INSURANCE COMPANY NAME ______________________

POLICY HOLDER NAME ______________ POLICYHOLDER DATE OF BIRTH ______________

WHAT PART OF THE BODY ARE WE TREATING YOU FOR? ______________________

WERE YOU INJURED IN AN AUTOMOBILE ACCIDENT? ________ IF SO, WHEN ______________

OTHER TYPE OF INJURY AND DATE ______________________

IF NO INJURY, HOWLONG HAS IT BEEN HURTING? ______________________

WHO REFERRED YOU TO OUR OFFICE? ______________________

NEAREST RELATIVE OR FRIEND NAME ______________ TELEPHONE # ______________

IF PATIENT IS UNDER 18 YEARS OF AGE:

FATHER'S NAME ______________ MOTHER'S NAME ______________

FATHER'S ADDRESS ______________ MOTHER'S ADDRESS ______________

______________ ______________

FATHER'S DATE OF BIRTH ______________ MOTHER'S DATE OF BIRTH ______________

FATHER'S SSN ______________ MOTHER'S SSN ______________

FATHER'S EMPLOYER ______________ MOTHER'S EMPLOYER ______________

FATHER'S WORK # ______________ MOTHER'S WORK # ______________

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plan to Carrollton Orthopaedic Clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize any physician or hospital to provide information on medical history and treatment to Carrollton Orthopaedic Clinic and I authorize photocopies of this form to be valid as the original.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signed: ______________________ Date: ______________

Form # Patient Information Sheet 7-14-05