Orthopaedic Specialists at Raulerson

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms.

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address _____

City, State _____ ZIP_____ Pharmacy_____Pharmacy Phone_____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

E-Mail Address:_____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address _____

City, State _____ ZIP_____

Home Phone _____ Work Phone _____ Ext. _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address _____

City, State _____ ZIP _____

Employer_____ Employer Phone Number_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Date of Birth MM _____/DD _____/YYYY _____ Social Security Number _____-_____-_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Date of Birth MM _____/DD _____/YYYY_____ Social Security Number _____-_____-_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____