**Please fill out both sides of this form completely. All information is necessary in order for us to file with your insurance. Please print.**

Office 0 1 Today's date: ___________________________

## Information Regarding Patient:

| | Last | First | Middle |
|---|---|---|---|
| Name: | | | |
| Address: | | | |
| City: | State: | Zip Code: | |
| Home Phone: ( ) | Mobile: ( ) | | |
| Your Physician (CIRCLE ONE): Dr. Cox Dr. Jablonsky Dr. Nixon Dr. Samuelson Dr. Meletiou Dr. Havenhill | | | |
| Social Security Number: | Primary Care Doctor: | | |
| Male / Female | Marital Status: | Date of Birth: | |
| Who Referred you to this Office? | | | |
| Patient's Employer: | | | |
| Employer's Phone Number: | | | |
| Employment Status (CIRCLE ONE): | Full Time | Part Time | Unemployed |
| Student Status (CIRCLE ONE): | Full Time | Part Time | N/A |

| Please List any Medications you are Taking: |
|---|
| |
| |
| Please List any Medications you are Allergic To: |
| |
| |
| |

**Is Your Injury Related To:** Motor Vehicle Accident ( ) yes ( ) no
Work Related Injury ( ) yes ( ) no

**In Case of Emergency, Contact (Nearest Relative *NOT* living with you):**

Name: ________________________________ Phone: ___________________________
Address: ______________________________________________________________
______________________________________________________________________
Relation to Patient: _____________________________________________________

**Information Regarding Insurance Policy:**

| Primary Insurance Company Name: | | |
|---|---|---|
| Name of Policy Holder: | | |
| Address of Policy Holder: | | |
| City: | State: | Zip Code: |
| Telephone Number: | Mobile: | |
| Policy Holder Social Security #: | | |
| Birth Date of Policy Holder: | Male / Female | |
| Policy Holder's Employer: | | |
| Policy Holder's Work Phone Number: | | |

| Secondary Insurance Company Name: | | |
|---|---|---|
| Name of Policy Holder: | | |
| Address of Policy Holder: | | |
| City: | State: | Zip Code: |
| Telephone Number: | Mobile: | |
| Policy Holder Social Security #: | | |
| Birth Date of Policy Holder: | Male / Female | |
| Policy Holder's Employer | | |
| Policy Holder's Work Phone Number: | | |

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO McHENRY COUNTY ORTHOPAEDICS FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THE SERVICES RENDERED. I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I UNDERSTAND THAT THE PROCESSING OF INSURANCE BY McHENRY COUNTY ORTHOPAEDICS IS DONE AS A COURTESY TO ME, AND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF THE MEDICAL BILLS INCURRED. IN THE EVENT THE ACCOUNT MUST BE REFERRED TO COLLECTION, I AGREE TO BE RESPONSIBLE FOR THE COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES, IF ANY.

Signed (PATIENT)
X_____________________________________________________________________

Signed (PATIENT' GUARDIAN)
X__________________________________________________________________