Proliance SURGEONS
Everett Bone & Joint

PATIENT INFORMATION

Name _____ Social Security # _____
Last First Middle

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown ❑ Declined

Race: ❑ African American ❑ American Indian, Alaska Native ❑ Asian ❑ Caucasian ❑ Native Hawaiian, Pacific Islander ❑ Other ❑ Declined

Preferred Language: ❑ English ❑ Spanish ❑ Other: _____ Interpreter Needed? Y ❑ N ❑

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner ❑ Widowed - *Interpreter Name* _____

Birthdate _____ Age _____ Male Female - *Interpreter Phone* _____

Home Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email Address _____

PRIMARY CARE PHYSICIAN:(FIRST & LAST NAME) _____ **REFERRED BY:** _____

EMPLOYMENT INFORMATION

Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Spouse/Parent/Domestic Partner _____ D.O.B. _____

Spouse/Parent Employer _____ Work Phone _____

In case of EMERGENCY: Relative to contact (not living with patient)

Name _____ Relationship _____ Ph# _____

Reason for this visit: Illness _____ Injury _____ Job related injury _____ Auto accident _____ Other _____

Date of injury or onset of problem _____ Part of body injured _____ ☐ Right ☐ Left

How did this happen? _____

If you were hospitalized for this: Where _____ When _____

INSURANCE INFORMATION

Primary Insurance _____ ID # _____ Group # _____

Subscribers Name _____ Subscriber's Date of Birth _____ Relationship to subscriber ☐ self ☐ spouse ☐ child

Claims Billing Address _____ Phone _____

Secondary Insurance _____ ID # _____ Group # _____

Subscribers Name _____ Subscriber's Date of Birth _____ Relationship to subscriber ☐ self ☐ spouse ☐ child

Claims Billing Address _____ Phone _____

Worker's Comp / Auto Insurance Carrier _____ Claim # _____

Address _____ Claim Mgr Name & Number _____ Date of Injury/Accident _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____

Relationship to patient _____ Social Security # _____ Birthdate _____

I acknowledge that I am financially responsible for all charges. I hereby authorize my insurance benefits to be paid directly to my physician. I also authorize the doctor and/or insurance company to release any information required for this claim.

Note: If the patient is under 18 years of age, the accompanying parent is responsible for all bills.

Signature _____ **Date** _____