STAFF INT: _____

TO ENSURE CORRECT BILLING, FILL OUT THIS FORM ACCURATELY & COMPLETELY. IF YOU HAVE ANY QUESTIONS, SEE THE FRONT OFFICE STAFF.

TO SEE DR: _____ TODAYS DATE: _____

PATIENT NAME: _____

ADDRESS: _____ CITY& STATE _____ ZIP: _____

PHONE: ( ) _____ SSN: _____-_____-_____

BIRTHDATE: _____ AGE: _____ MARITAL STATUS: _____ SEX: M F

EMPLOYER NAME: _____ OCCUPATION: _____

WORK ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: ( ) _____ EXT: _____

CELL PHONE: ( ) _____ E-MAIL ADDRESS: _____

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY: _____ STATE & ZIP: _____

PHONE: ( ) _____ INSURED'S NAME: _____

RELATION TO INSURED: _____ INSURED'S BIRTHDATE: _____

INSURED'S ID#: _____ POLICY/GROUP #: _____

INSURED'S EMPLOYER NAME & PHONE: _____

SECONDARY INSURANCE NAME (IF APPLICABLE) _____

INSURED'S NAME: _____ RELATION: _____ EMPLOYER: _____

INSURED'S ID#: _____ POLICY/GROUP #: _____ BIRTHDATE: _____

PARENT/GUARDIAN NAME: _____

PHONE: ( ) _____ RELATION TO PATIENT: _____

EMERGENCY CONTACT NAME & PHONE: _____

WHO REFERRED YOU: _____ DR.: _____

DATE OF INJURY: _____ RELATED TO: WORK COMP. _____ AUTO _____ OTHER _____

CHIEF COMPLAINT OR SYMPTOMS: _____

LIST ANY ALLERGIES: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REGARDING MY CLAIMS. I HEREBY DIRECT AND AUTHROIZE PAYMENT FOR ALL MEDICAL AND SURGICAL BENEFITS TO SANTA MONICA ORTHOPAEDIC AND SPORTS MEDICINE GROUP, INC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR SETTLEMENT OF MY ACCOUNT. SHOULD ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, THE UNDERSIGNED SHALL PAY ACTUAL ATTORNEYS FEES AND COLLECTION EXPENSES.

SIGNATURE: _____ RELATION: _____ DATE:
(PATIENT, PARENT, GUARDIAN)