BATON ROUGE ORTHOPAEDIC CLINIC

Pt. ID #

Welcome to the Baton Rouge Orthopaedic Clinic. We are committed to providing the best, most comprehensive orthopaedic care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line. If you need assistance filling out this form please notify the receptionist.

Demographics

Please print all information.

Patient's Name:		**Today's Date:**
Sex: (circle one) **Male** **Female**	**Date of Birth:**	**Age:**
Address:		
City:	**State:**	**Zip Code:**
Social Security Number:	**Drivers license number and state:**	
Home Telephone:	**Work Telephone:**	**Cell Telephone:**
If a minor name of guardian and relationship:		

Notify in Case of Emergency

Name:		**Relationship:**
Home Telephone:	**Work Telephone:**	**Cell Telephone:**

Billing Information

Who is Responsible for the bill?

Workers Compensation ◯ Company Name: ____________________

Primary Insurance Company ◯ Insurance Company: ____________________

Insurance Address, City, State, Zip: ____________________ Telephone Number: __________

Name of Insured: ____________________ Insured Date of Birth: __________

Contract or Policy Number: ____________________ Group Number: __________

Secondary Insurance Company ◯ Company Name: ____________________

Insurance Address, City, State, Zip: ____________________ Telephone Number: __________

Name of Insured: ____________________ Insured Date of Birth: __________

Contract or Policy Number: ____________________ Group Number: __________

Self Payment ◯

Employment History

Are you currently employed? Yes ◯ No ◯ Name of Employer: ____________________ What is your job title: __________

Briefly what are your job duties: ____________________

Problem

Part of body to be checked: ____________________ How long have you had these symptoms: __________

Nature of problem: Other ◯ Injury ◯ Do you have x-rays: Yes ◯ No ◯ Date of injury: __________

How did injury occur: ____________________ Have you been treated for this problem by another doctor: Yes ◯ No ◯

If yes, please list all physicians seen for this problem: ____________________

Who can we thank for referring you to our clinic? ____________________

Who is your Primary Care Physician? ____________________

I hereby assign my insurance benefits plan for medical services rendered to Baton Rouge Orthopaedic Clinic. I understand that I am financially responsible for any charges not covered by this assignment; payment of all services rendered, regardless of insurance coverage or other third party liability; and pay all costs of collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection. I also hereby authorize the release of information required in the course of my examination as may be needed to process my insurance.

Signature: ____________________ Date: __________

REORDER # 03-22358-30