PATIENT DEMOGRAPHIC & INSURANCE INFORMATION FORM 2

MCCAIN ORTHOPAEDIC CENTER

Patient Information Name Date _____

___Mr. _____ Male _____
___Mrs _____.
___Miss _____ Female _____ Age__

Birthdate _____Single___Married___Divorced___Widowed___

Name of Person Legally Responsible _____
(If patient is a minor, name of parent or guardian

School _____

Home Mailing Address _____
_____Home Phone _____

Patient Social Security No. _____Drivers License No._____

Patient Employed By _____Occupation_____

Business Address _____Bus Phone _____

Name of Spouse or Parent _____Age___ Birthdate_____

Social Security No. _____Employed by _____

Business Address _____Business Phone_____

Nearest Relative Not Living With You _____Phone _____

Do you have Medicare? No___ Yes____ Number _____

Do You have Medicaid? No___ Yes___ Number _____

Name of Insurance Company_____ Insured's Name_____
Policy or group# _____
Address _____ Copayment Office _____
Copayment Surgery _____
In Whose Name is Insurance? _____ Coinsurance _____
Deductible _____
Is This Workmens Compensation? _____

RELEASE AND ASSIGNMENT: I hereby consent to any necessary medical treatment for myself, child, or the above named minor, for whom I am legally responsible. The release of medical information to any insurance carrier, and direct payment to McCain Orthopaedic Center for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of charges for medical service rendered.

Signed _____Date_____