

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 _____

Address _____ Policy or group# _____
Copayment Office _____

In Whose Name is Insurance? _____ Copayment Surgery _____

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 _____