ACADIANA ORTHOPEDIC GROUP

PATIENT INFORMATION

Patient's Name _____ (LAST) _____ (FIRST) _____ (MIDDLE)

What Doctor will you be seeing today: (Leonard, Schutte, Duval, Foster, Hebert, Yerger, Williams)

Patient's Physical Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

SS #: _____ Drivers License #: _____ Birth Date: _____ Age: _____ Sex: _____

Home Phone: _____ Alternate Phone (Cell): _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

Marital Status: Married Single Divorced Widowed Separated (Please circle one)

Reason for Appointment: (Knee, ankle, shoulder, wrist, back, etc.) _____

Is this Injury a result of an accident? Yes or No If yes, what type of accident? Work related Auto accident Other

Date of onset, injury, or accident _____ Referred by: _____

Have you ever been seen by any one of the Physicians in this office? YES NO

Patient's Employer: _____ Employer Phone: _____

Employer Address: _____ Patient's Occupation: _____

Spouse's Name: _____ Occupation: _____ Spouse's Employer: _____

Employer's Phone: _____ Employer's Address: _____

IF PATIENT IS A DEPENDENT

Father's Name: _____ Employer: _____

Occupation: _____ Employer Phone: _____

Mother's Name: _____ Employer: _____

Employer Phone: _____ Occupation: _____

INSURANCE

Medicare #: _____ Medicaid #: _____

Insurance Company: _____ Phone #: _____

Address: _____ Policy #: _____

_____ Group #: _____

Name of Policyholder if other than patient: _____ Policyholder's SS#: _____

Policyholder's Date of Birth: _____ Policyholder's Phone #: _____

Policyholder's Address: _____

IF YOU WERE INJURED WHILE AT WORK

Employer at time of Injury: _____ Employer's Phone: _____

Date of injury: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize **AOG** to furnish my insurance company(s), attorney and/or workers' comp. representative information that they may request concerning my illness or injury, written or verbal.

I hereby assign **AOG** all money to which they are entitled for medical and/or surgical expenses. Any credit balance will be refunded to the rightful party.

I agree to pay the amount due in full at the time of services (unless prior arrangements were made) and collection/attorney fees that are added to the unpaid balance.

I understand that I am financially responsible for any balance not covered by my insurance.

Signed: _____ (PATIENT OR PARENT / GUARDIAN) _____ (DATE)