RADFORD ORTHOPEDIC CENTER, P.C. ***DATE:_____***

http://www.Radford Ortho.com

All information must be filled out otherwise you will be asked for information at front desk.

CHILD (UNDER AGE 18 YEARS-OLD

Patients Name:_____**SS#**_____
Street address:_____**City/State/Zip**_____
MailingAddress:_____**City/State/Zip**_____
Phone #:_____ **Date of Birth**: _____ **Are you a student?**: YES NO
Where are you a student? _____ Are you a fulltime student? YES NO
Emergency contact (other than parents):_____

Father's Name:_____**SS#**_____
Street Address:_____**Mailing Address**:_____
Phone#_____**County in which you live**_____
Employer_____**Address:**_____
Employer's phone #_____**Extension**:_____ **Date of birth**: _____

Mother's Name:_____**SS#**_____
Street Address:_____**Mailing Address**:_____
Phone#_____**County in which you live**_____
Employer:_____**Address**:_____
Employer's phone #_____**Extension**:_____ **Date of birth**: _____

*** May we refer to you by your name in our waiting room?** YES NO
*** May we call you concerning labs, x-rays & appointments, ect.?** YES NO
*** May we leave a message on your answering machine concerning the above?** YES NO
*** Please list all individuals with whom we may speak concerning you:**

_____

_____

Name of Pharmacy:_____Phone # or location:_____
Referring Physician:_____ Phone#_____
Primary Care Physician:_____

I hereby authorize my insurance company to pay directly to Radford Orthopedic Center, P.C. benefits due me out of indemnity under the terms of my policy issued by your company. I also authorize the release of any medical information necessary to process this claim, and verification of employment.

I understand that I am financially responsible to Radford Orthopedic Center, P.C. for all charges incurred and not covered by the insurance, workers compensation and any collection, attorney fees, interest and/or cost accrued in trying to collect this account.

Parent's Signature:_____
Date

I have insurance that requires a referral from my Primary Care Physician. <u>I understand that if I do not get my referral from my PCP I am responsible for the bill in its entirety at Radford Orthopedic Center.</u>

Parent's Signature:_____
Date