

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.

Patients Name: _____ **SS#** _____

Street Address: _____ **City/State/Zip** _____

Mailing Address: _____ **City/State/Zip** _____

Phone: _____ **Date of birth:** _____ **County in which you live** _____

Marital Status: Married Divorced Widowed Single Separated

Employer _____ **Address:** _____

Employer's phone # _____ **Is this Workman's Compensation?** YES NO

Is this a personal injury? YES NO

Friend or relative not living with you: _____ **Phone #** _____

Other responsible party: **Spouse Information:**

Name: _____ **SS#** _____

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:**

Person to notify in case of an emergency other than spouse: _____

Phone# _____

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.

Patient's Signature: _____

Date

I have insurance that requires a referral from my Primary Care Physician. 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.

Patient's Signature: _____

Date

I understand that if this is a personal injury I will be responsible for my own bill and Radford Orthopedic Center, P.C. will not be expected to await settlement.

* **Patient's Signature:** _____