

Joint Reconstructive Specialist Patient Information Sheet

Date _____

JRS Account # _____

Personal Information

Last Name: _____ First Name: _____ M: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Social Security #: _____ DOB: _____

Age: _____ Sex: _____ Marital Status: _____

Employer: _____ Employer Phone #: _____

Spouses Information or Responsible Party

Last Name: _____ First Name: _____ M: _____

Social Security #: _____ DOB: _____

Employer: _____

Emergency Contact

Name: _____ Telephone#: _____

Relationship to you: _____

Physician

Primary Care Doctor: _____ Telephone #: _____

Address: _____

Referring Doctor: _____ Telephone #: _____

Please turn over to fill out the insurance portion and sign the authorization for billing purpose. Thank you.

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Insurance Information

Primary

Ins. Carrier Name: _____

Policy #: _____ Group #: _____

Name of policyholder if different from patient: _____

Secondary

Ins. Carrier Name: _____

Policy #: _____ Group #: _____

Workers Compensation Information if Applicable

Claim #: _____ DOI: _____

Employer: _____

Employer Phone Number: (_____) _____

Insurance Carrier (if known): _____

Insurance Carriers Address: _____

OFFICE POLICIES

1. I understand that I am financially responsible for any balance not covered by my insurance carrier.
2. I understand that co-payments are due at time of visit.
3. I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.
4. I understand that I am responsible for providing a referral from my primary care (PCP) should my insurance carrier require one, and that if one is not received my appointment will be cancelled.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize *Joint Reconstructive Specialist* to furnish information to insurance carriers and/or third party payers concerning my illness & treatment. Therefore, I understand I am fully responsible for all fees incurred for service(s) rendered. I hereby assign to the doctor all my payments for medical services rendered to my dependent(s) or myself. I understand this authorization will remain in effect for as long as my dependent(s) or myself remain a patient.

Signature of

Patient or

Parent/Guardian: _____ **Date :** _____