# NEW PATIENT INFORMATION RECORD

(Please print or write legibly) Date: _____

| PATIENT'S NAME: (FIRST MI LAST) | SEX | MARITAL STATUS | | | | | AGE | BIRTH DATE | SOCIAL SECURITY NO. |
|---|---|---|---|---|---|---|---|---|---|
| | M F | S | M | W | DIV | SEP | | | |
| | ❑ ❑ | | | | | | | | |

| STREET ADDRESS ❑ PERMANENT ❑ TEMPORARY | CITY & STATE | ZIP CODE | HOME PHONE # |
|---|---|---|---|
| MAILING ADDRESS/WINTER VISITOR PERMANENT ADDRESS | | CITY & STATE | ZIP CODE |
| PATIENT'S EMPLOYER | OCCUPATION (indicate if student) | HOW LONG EMPLOYED? | BUSINESS PHONE # |
| EMPLOYER'S STREET ADDRESS | CITY & STATE | | ZIP CODE |
| SPOUSE OR MINOR'S MOTHER, FATHER OR LEGAL GUARDIAN'S NAME | | | |
| SPOUSE OR GUARDIAN'S EMPLOYER | OCCUPATION (indicate if student) | HOW LONG EMPLOYED? | BUSINESS PHONE # |
| EMPLOYER'S STREET ADDRESS | CITY & STATE | | ZIP CODE |

NAME OF NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU: _____ PHONE #_____

CITY: _____ STATE: _____ ZIP CODE: _____

# BILLING INFORMATION

GUARANTOR, if different from above. *Self, Spouse, Father, Mother, Guardian (Circle One):* _____

GUARANTOR'S ADDRESS (Street): _____

CITY: _____ STATE: _____ ZIP CODE: _____

GUARANTOR'S EMPLOYER/OCCUPATION: _____ HOW LONG EMPLOYED? _____ BUSINESS PHONE #: _____

EMPLOYER'S STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GUARANTOR'S BIRTH DATE: _____ GUARANTOR'S DRIVER'S LICENSE #: _____ SS #: _____

# INSURANCE INFORMATION

❑ NO COVERAGE ❑ HMO/PPO ❑ MEDICARE ❑ INDUSTRIAL ❑ OTHER

| PRIMARY INSURANCE: | SECONDARY INSURANCE: |
|---|---|
| ADDRESS: | ADDRESS: |
| CITY: STATE: ZIP: | CITY: STATE: ZIP: |
| INSURED'S NAME: | INSURED'S NAME: |
| INSURED'S ID OR SS#: | INSURED'S ID OR SS#: |
| GROUP # OR COMPANY NAME: | GROUP # OR COMPANY NAME: |
| EFFECTIVE DATE: | EFFECTIVE DATE: |
| RELATIONSHIP TO INSURED: ❑ Self ❑ Spouse ❑ Child | RELATIONSHIP TO INSURED: ❑ Self ❑ Spouse ❑ Child |

IF ACCIDENT, WERE YOU INJURED ON THE JOB? INDUSTRIAL CLAIM #: _____

❑ YES ❑ NO DATE OF INJURY PHONE# CONTACT

IF ACCIDENT, WAS AN AUTOMOBILE INVOLVED? NAME OF ATTORNEY: _____

❑ YES ❑ NO DATE OF INJURY PHONE# CONTACT

HAS ANY MEMBER OF *YOUR IMMEDIATE FAMILY* BEEN TREATED BY OUR PHYSICIAN(S) BEFORE?

❑ YES ❑ NO DATE: _____ NAME(S): _____

HAVE YOU PURSUED ANY MEDICAL LITIGATION? ❑ YES ❑ NO DATE: _____ IS THE CASE PENDING? ❑ YES ❑ NO

## PLEASE READ THE FOLLOWING:

ALL CHARGES INCLUDING COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING COMPLETED INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

**DON'T HESITATE TO DISCUSS YOUR ACCOUNT WITH THE BILLING DEPARTMENT**

# PAYMENT AGREEMENT

The undersigned agrees (whether signing as agent representative, or as patient and whether or not insured or a member of a health maintenance organization), that, in consideration of the services to be rendered to the patient, he or she is hereby individually obligated to pay the account of *Sierra Orthopedics, P. C.* , in accordance with the regular rates and terms of said medical provider.

Should *Sierra Orthopedics, P. C.'s* , account be referred for collection, the undersigned agrees to pay reasonable collection expenses, billing fees, counsel fees and court costs.

Unless specifically agreed otherwise by *Sierra Orthopedics, P. C.* in writing, no action or inaction on it's part related to billing or payment of patient expenses shall in any manner be construed as an admission of liability or as a wavier by *Sierra Orthopedics, P. C.* ,of it's right to collect it's charges.

GUARANTOR'S SIGNATURE: _____ DATE: _____

(Relationship to Patient): _____

WITNESS'S SIGNATURE: _____ DATE: _____

**AUTHORIZATION TO PAY BENEFITS TO PHYSICAN**: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THOMAS L. ERICKSON, M.D. or *Sierra Orthopedics, P. C.* for the Surgical and/or Medical Benefits, if any, otherwise payable to me for their services, but not to exceed the reasonable and customary charge for those services.

**AUTHORIZATION TO RELEASE INFORMATION**: I HEREBY AUTHORIZE *Sierra Orthopedics, P. C.* to release any information acquired in the course of my examination or treatment.

INSURED'S SIGNATURE: _____ DATE: _____

LEGAL GUARDIAN'S SIGNATURE: _____ DATE: _____

(Relationship to Patient): _____

**CONSENT TO TREAT A MINOR: I HEREBY GIVE MY CONSENT FOR TREATMENT.**

LEGAL GUARDIAN'S SIGNATURE: _____ DATE: _____

(Relationship to Patient): _____

**PLEASE FEEL FREE TO DISCUSS YOUR ACCOUNT WITH THE BILLING DEPARTMENT**