Today's date:	*Account# Office use only*	
Patients last name:	First name:	
Address:		
City:	State:	Zip:
Home:☎	Work: ☎	
Cell: ☎	E-mail:	
Social Security#	Birth:	
Height:	Weight:	
Occupation:	Employer:	
Employer address:	Employer city:	
State: / Zip:	Have you been in this office before?	❑ yes ❑no
Referring Physician:	Phone: ☎	
Person financially responsible:		

Primary Insurance:	ID:	Group:
Address:	Phone :	
City:	State:	Zip:
Subscribers last name:	Subscribers first name:	
Subscribers social security#	Subscribers date of birth:	
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child ❑ Other

Secondary Insurance:	ID:	Group:
Address:	Phone :	
City:	State:	Zip:
Subscribers last name:	Subscribers first name:	
Subscribers social security#	Subscribers date of birth:	
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child ❑ Other

If you are covered through Workers Comp. or Motor Vehicle Insurance please also complete below.

Insurance name:
Claims adjuster:
Adjuster phone:
Claim#

Please read and sign below:
The above information is true to the best of my knowledge. I understand that missing information on this form can delay insurance payment.
I authorize this Swiss Orthopedic to release any information necessary to expedite insurance claims. I understand that I am financially responsible for all charges, regardless of insurance coverage.

Patient/Guardian Signature: **Date:**