Patient Data

Name and relation of any family member seen here before____

PATIENT NAME:____
(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS:____

STREET ADDRESS:____

CITY-STATE-ZIP:______________________________HOME PHONE#________________________

EMPLOYER___________________________________WORK PHONE#________________________

SEX: M F MARITAL STATUS: S M W D CELL PHONE#_________________________

BIRTHDATE___________ RETIRED: Y N DISABLED: Y N SS#_________________________

SPOUSE NAME:________________________________SOCIAL SECURITY#___________________

SPOUSE'S EMPLOYER:___________________________WORK PHONE#______________________

HOW DID YOU CHOOSE OUR OFFICE? ____

CAN WE CALL YOU AT WORK? Y N CAN WE MAIL AN OPEN POSTCARD FOR APPT PURPOSES? Y N
CAN WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME AND/OR WORK? Y N

EMERGENCY INFORMATION
NEAREST RELATIVE: (NOT LIVING WITH YOU)______________________PHONE#_________________

NEIGHBOR OR FRIEND____PHONE#___________________

REASON FOR VISIT: INJURY___AUTO ACCIDENT___JOB RELATED___LONG STANDING PROBLEM___
PAYMENT: CASH_______ CHECK_______ CREDIT CARD_______ WORKER'S COMP_______

**I understand that I am financially responsible for all charges whether or not paid by my insurance. I have received the Credit Policy and understand its contents.
**I , the undersigned, have insurance coverage (see attached) and assign payment directly to CANTON ORTHOPAEDICS & WorkersCare, for all surgical/medical benefits that I have not paid for.

POLICY HOLDER SOCIAL SECURITY#______________________ DATE OF BIRTH_________________
**I hereby authorize CANTON ORTHOPAEDICS & WorkersCare to release any medical, psychiatric, infectious disease, or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim, utilization review or quality assurance activities. I authorize the release of the above information to my employer, adjustor, and/or nurse case manager for any work related injury.
**I hereby authorize CANTON ORTHOPAEDICS & WorkersCare to send my medical records, patient data information & insurance information to physicians, facilities and any provider who may participate in my care upon request by CANTON ORTHOPAEDICS & WorkersCare. Release of medical data includes redisclosure of medical information obtained from other providers in accordance with your wishes.
**I understand that should it become necessary to turn my account over to a collection agency that I will be responsible for all collection and attorney fees. I also understand that a copy of my patient data sheet, statement of my account and any other billing information needed will be released to the collection agency.
**I have read and understand Canton Orthopaedics & WorkersCare's Notice of Privacy Practices and by signing below I am giving consent to the release of my protected health information as indicated.

DATE______________________ SIGNATURE______________________________________
***If patient is a minor, please complete information on the other side of this form.

PARENT OR GUARDIAN DATA (PLEASE FILL OUT IF UNDER 18 YEARS OF AGE)

MOTHER'S NAME:____SOCIAL SECURITY#_________________________

ADDRESS IF DIFFERENT:____HOME PHONE#_______________________

EMPLOYER:___________________________________WORK#__________________CELL#______________________

FATHER'S NAME____SOCIAL SECURITY#_________________________

ADDRESS IF DIFFERENT:____HOME PHONE#_______________________

EMPLOYER____________________________________WORK#____________________CELL#____________________