# ALLSTAR ORTHOPEDICS

## THE WINNING CHOICE

## PATIENT DEMOGRAPHIC INFORMATION

Is today your first visit with Allstar Orthopedics? YES NO Today's Date _________

### PERSONAL INFORMATION

**NAME:** ______________________________________________

ADDRESS:______________________________________________PHONE #__________________

CITY: ______________________________ STATE: ____________ ZIP CODE: __________

SOCIAL SECURITY #: _____________________ DOB: __________________ AGE: ________

SEX__________________ MARITAL STATUS_______________

EMPLOYER NAME ______________________________________PHONE_________________

**SPOUSE NAME :**______________________________________________

SOCIAL SECURITY#_______________________ DOB___________________________________

EMPLOYER NAME & ADDRESS: ____________________________________________________

CITY_______________________STATE_______________________ZIP CODE_______________

EMPLOYER PHONE NUMBER: _______________________

### INSURANCE INFORMATION

Primary Insurance______ _____________________Policy #_______________________________

Secondary Insurance: ________________________Policy #_______________________________

### RESPONSIBLE PARTY/GUARANTOR INFORMATION

Name: ____________________________________ Relationship to Patient: __________________

Social Security #: ____________________________ DOB: __________ Age: ________________

Address: _________________________ City________________ State: ______ Zip: ___________

Home Phone # : ______________________ Employer Phone # _____________________________

Employer: ___________________________Employer Address: _____________________________

City:________________________________ State: ____________ Zip Code: __________________

### HOW DID YOU HEAR ABOUT ALLSTAR ORTHOPEDICS & DR BLACK

# ALLSTAR ORTHOPEDICS
## THE WINNING CHOICE

**_______NEWS PAPER _______T.V. _______PHONE BOOK __________ER**

**REFERRING PHYSICIAN_____________________FRIEND____________________**

**PATIENT_________________________**

## ONSET OF INJURY REPORT
**THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR ALL INSURANCE TYPES**

DATE PROBLEM STARTED_______________________ WORK RELATED? YES OR NO

EMPLOYER'S NAME: __________________________________________________

ADDRESS: ________________________________________________________

DATE RETURNED TO WORK__________________________

WAS ACCIDENT AUTO RELATED? YES OR NO

____________________________________
(INSURED)

## PAYMENT POLICY

ALL CHARGES ARE DUE AT THE TIME SERVICES ARE RENDERED.

All professional services rendered are charged to the patient. The charges will be filed with your insurance company. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

**INSURANCE AUTHORIZATION AND ASSIGNMENT** (PLEASE READ AND SIGN)

I hereby authorize Allstar Orthopedics to furnish information to insurance carriers & referring physician concerning my illness and treatments.
**SIGNATURE (X) _______________________________________ DATE________________**

I hereby assign to Allstar Orthopedics all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

**SIGNATURE (X) ___________________________________________ DATE____________**