Henry County
Orthopaedic Surgery And
Sports Medicine, PC

CHART # ______________________

(PLEASE PROVIDE CARD FOR US TO COPY)

Patient's Full Name: ____________________ Driver's License #: ____________________

Spouse or Parent Name: ____________________ Driver's License #: ____________________

Patient's Address: ____
No. Street City State Zip

Spouse or Parent Address: ____
No. Street City State Zip

Patient's Home Phone #: (   ) ____________________ Patient's Cell Phone #: (   ) ____________________

Patient's Work Phone #: (   ) ____________________ Ext.: ________ Email: ____________________

S.S. # ____________________ DOB: ____________________ Age: ________ ❑ Male ❑ Female ❑ Married ❑ Single

Spouse or Parent Home#: ____________________ Work #: ____________________ Cell #: ____________________

Employer Address: ____
No. Street City State Zip

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT:

Name: ____________________ Relationship to Patient: ____________________

Work Phone #: ____________________ Home Phone #: ____________________

Address: ____
No. Street City State Zip

❑ Referred by Dr.: ____________________ Your Primary Care Physician: ____________________

How did you hear about us? ❑ Friend / Family ❑ Yellow Pages ❑ Newspaper Ad In ____________________

IS THIS VISIT RELATED TO AN ACCIDENT OR A SPECIFIC EVENT? ❑ YES ❑ NO IF SO, DATE OF INJURY ____________

PLACE OF INJURY: ❑ WORK ❑ AUTO ❑ SLIP/FALL ❑ SPORTING EVENT ❑ OTHER: ____________

Living Will: ❑ yes ❑ no Power Of Attorney: ____________________ Date: ____________

PRIMARY INSURANCE (Please provide insurance card for us to copy)

Name of Insured: ____________________ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other ________

DOB: ____________ Member#: ____________ Group #: ____________ S.S. #: ____________________

Effective Date: ____________ Referral Required: ❑ Yes ❑ No Co-Pay:$ ________ Deductible: $ ________

SECONDARY INSURANCE (Please provide insurance card for us to copy)

Name of Insured: ____________________ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other ________

DOB: ____________ Member#: ____________ Group #: ____________ S.S. #: ____________________

Effective Date: ____________ Referral Required: ❑ Yes ❑ No Co-Pay:$ ________ Deductible: $ ________

Signature on File

____

____
Date

Assignment of Benefits -- Financial Agreement -- Release Medical Records

I hereby give lifetime authorization for payments of insurance benefits to be made directly to **HENRY COUNTY ORTHOPAEDIC SURGERY & SPORTS MEDICINE, INC.** for services rendered. I understand that my insurance will be filed but after 60 days, payment will be shifted to my responsibility. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay ALL costs of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure payment of benefits, and do hereby release **HENRY COUNTY ORTHOPAEDIC SURGERY & SPORTS MEDICINE, INC.** from all legal liability that may arise from the release of information requested. I further agree that a photocopy of this agreement shall be valid as the original.

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