

Date: \_\_\_\_\_

## ALPINE BONE & JOINT CLINIC

### PATIENT INFORMATION

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First MI

Responsible Party (if minor): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: \_M \_F Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Referred By: \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### PRIMARY INSURANCE

Is this work Related: \_\_yes \_\_no If yes, Date of Injury: \_\_\_\_\_ Claim No: \_\_\_\_\_

Employer at Date of Injury: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Group No.: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

### ADDITIONAL INSURANCE

Name of Insured: \_\_\_\_\_ Group No.: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

## ASSIGNMENT AND RELEASE

The undersigned hereby authorizes the release of any information relating to all claims for insurance benefits submitted on behalf of dependents or myself. I further authorize the release of records pertaining to dependents or myself to other physicians and/or my attorney. I understand that I am financially responsible for all charges whether or not paid by insurance.

X \_\_\_\_\_

Signature of patient or parent if minor

\_\_\_\_\_

Date