# PEDIATRIC ORTHOPAEDIC ASSOCIATES, P.C.

## Patient Information

| Patient's Last Name First Middle | SS # | Birth Date ____ ____ _____ | Age | Sex M F |
|---|---|---|---|---|
| | | | | |

| Street Address | City and State | ZIP Code | Home Phone # ( ) |
|---|---|---|---|
| | | | |

| Mother's Name | SS # | Birth Date ____ ____ _____ |
|---|---|---|
| | | |

| Street Address | City and State | ZIP Code | Home Phone # ( ) |
|---|---|---|---|
| | | | |

| Employer's Name & Address | Work Phone # ( ) |
|---|---|
| | |

| Father's Name | SS # | Birth Date ____ ____ _____ |
|---|---|---|
| | | |

| Street Address | City and State | ZIP Code | Home Phone # ( ) |
|---|---|---|---|
| | | | |

| Employer's Name & Address | Work Phone # ( ) |
|---|---|
| | |

| Automobile or other accident? Y N | Date of accident | Location/brief details |
|---|---|---|
| | | |

| Referring Doctor's Name | Address | Phone # ( ) |
|---|---|---|
| | | |

| Family Doctor/Pediatrician (if different from above) | Address | Phone # ( ) |
|---|---|---|
| | | |

**Emergency Contact** - Residing at a different address (i.e. friend or relative)

| Last Name First Middle | Phone # ( ) |
|---|---|
| | |

## Insurance Information

| Do you have health insurance? Y N | If yes, please complete the following: | |
|---|---|---|
| | | |

| Primary Insurance Carrier | Address | Phone # ( ) |
|---|---|---|
| | | |

| Policy No. (ID No.) | Group No. |
|---|---|
| | |

| Name of Policy Holder | Relationship |
|---|---|
| | |

| Secondary Insurance Carrier | Address | Phone # ( ) |
|---|---|---|
| | | |

| Policy No. (ID No.) | Group No. |
|---|---|
| | |

| Name of Policy Holder | Relationship |
|---|---|
| | |

Patient Authorization:
I hereby authorize Pediatric Orthopaedic Associates, P.C., to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier. I hereby assign payment of benefits directly to Pediatric Orthopaedic Associates, P.C. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that the authorization shall be valid until rescinded in writing or replaced by one of a later date. I authorize the physicians of Pediatric Orthopaedic Associates P.C. to treat the above patient. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Signature: _____ Date: _____

If patient is a minor, parent or legal guardian signature