



BATON ROUGE ORTHOPAEDIC CLINIC

Pt. ID #

Welcome to the Baton Rouge Orthopaedic Clinic. We are committed to providing the best, most comprehensive orthopaedic care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line. If you need assistance filling out this form please notify the receptionist.

Demographics

Please print all information.

Patient's Name:		Today's Date:	
Sex: (circle one) Male Female	Date of Birth:	Age:	
Address:			
City:	State:	Zip Code:	
Social Security Number:		Drivers license number and state:	
Home Telephone:	Work Telephone:	Cell Telephone:	
If a minor name of guardian and relationship:			

Notify in Case of Emergency

Name:		Relationship:	
Home Telephone:	Work Telephone:	Cell Telephone:	

Billing Information

Who is Responsible for the bill?	
Workers Compensation <input type="radio"/>	Company Name: _____
Primary Insurance Company <input type="radio"/>	Insurance Company: _____
Insurance Address, City, State, Zip: _____ Telephone Number: _____	
Name of Insured: _____ Insured Date of Birth: _____	
Contract or Policy Number: _____ Group Number: _____	
Secondary Insurance Company <input type="radio"/>	Company Name: _____
Insurance Address, City, State, Zip: _____ Telephone Number: _____	
Name of Insured: _____ Insured Date of Birth: _____	
Contract or Policy Number: _____ Group Number: _____	
Self Payment <input type="radio"/>	

Employment History

Are you currently employed? Yes <input type="radio"/> No <input type="radio"/>	Name of Employer: _____	What is your job title: _____
Briefly what are your job duties: _____		

Problem

Part of body to be checked: _____	How long have you had these symptoms: _____
Nature of problem: Other <input type="radio"/> Injury <input type="radio"/>	Do you have x-rays: Yes <input type="radio"/> No <input type="radio"/>
Date of injury: _____	
How did injury occur: _____	Have you been treated for this problem by another doctor: Yes <input type="radio"/> No <input type="radio"/>
If yes, please list all physicians seen for this problem: _____	
Who can we thank for referring you to our clinic? _____	
Who is your Primary Care Physician? _____	

I hereby assign my insurance benefits plan for medical services rendered to Baton Rouge Orthopaedic Clinic. I understand that I am financially responsible for any charges not covered by this assignment; payment of all services rendered, regardless of insurance coverage or other third party liability; and pay all costs of collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection. I also hereby authorize the release of information required in the course of my examination as may be needed to process my insurance.

Signature: _____ Date: _____