

DR  2401  2402

Official Office Use (Account Number) \_\_\_\_\_



DATE OF YOUR APPOINTMENT \_\_\_\_/\_\_\_\_/\_\_\_\_

UNIVERSITY DIVISION \_\_\_\_\_ E-mail address \_\_\_\_\_

Patient Name		First	M	Last	Date of Birth	Age
Sex		City		State		Zip Code
Address		City		State		Zip Code
Home Phone:	SOCIAL SECURITY NUMBER			Work Phone	Cell Phone	Email Address
<u>REFERRING PHYSICIANS NAME:</u>				<u>PRIMARY CARE PHYSICIAN:</u>		
Employer Name & Address				Occupation		
Spouse's Name		Spouse's Employer Name			Spouse Work Phone	
NAME OF PERSON RESPONSIBLE FOR PAYMENT : SSN				SUBSCRIBERS DOB		SUBSCRIBERS
Address		Street		City		State Zip code
Home Phone		Work Phone		Emergency Contact (Name & Phone)		
Employer's Name & Address						
<u>PRIMARY HEALTH INSURANCE CO</u>			POLICY ID NO.		GROUP NO.	
Primary Insurance Address						
<u>SECONDARY HEALTH INSURANCE CO.</u>			POLICY ID NO		GROUP NO.	
AUTO ACCIDENT		Yes	No	Date of Accident		Your Auto Insurance Company
WORK RELATED INJURY		DATE OF INJURY		COMPENSATION INSURANCE CARRIER		
YES		No	/	/		
<b>Employer at time of injury</b>						
<b>FOR WOMEN ONLY:</b> Are you currently Pregnant or Have suspicions of Pregnancy No Yes   If yes, first day of LMP :						

I certify that the information I have reported with regards to my insurance coverage is correct and hereby authorize the Jacksonville Orthopaedic Institute to apply for benefits on my behalf for covered services rendered by the Jacksonville Orthopaedic Institute. I request payment be made directly to the Jacksonville Orthopaedic Institute. I understand that I am financially responsible for any balance not covered by my insurance or is deemed my responsibility by my insurance carrier.

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Signature of Patient or Parent/Guardian Date