Name, (Last, First, Middle) ☐ Mr. ☐ Ms. ☐ Dr. Social Security No.		
Parent/Guardian	Home Phone #:	Work Phone #:
Address	City	State Zip
Date of Birth Age	Marital Status ☐ Single ☐Married ☐Divorced ☐Separated ☐Widowed	Sex ☐Male ☐Female
Place of Employment	Employment Address	State Zip
In emergency, contact information:	Relationship	Phone #:
REASON FOR VISIT		Date of Onset
Name of Primary Care Physician		☐ WC ☐MVA ☐Other

HEALTH INSURANCE INFORMATION

Primary Insurance Carrier Name		
Insurance Carrier Address	City	State Zip
Name of Insured	Relationship ☐ Self ☐ Spouse ☐ Child	Insured's Phone #:

ID#	Group #
Secondary Insurance	ID#
Lawyer's Name (if applicable, e.g. accident)	Lawyer's Phone #:
Lawyer's Address	City State Zip

When you engage the services of an attorney, you must notify this office immediately.

AGREEMENT

In consideration of the examination to be provided by South Palm Orthopedics:
I understand that the doctor makes no representations about my condition other than those concerning the problem for which he has been retained. I hereby authorize South Palm Orthopedics (SPO) to furnish information to insurance carriers regarding illness and treatments to me and/or my dependants and to obtain a release of medical information in writing, by e-mail, fax, or through electronic assignment to the appropriate parties as needed. I authorize release of all information necessary to secure payment. I hereby assign to SPO any and all benefits, payments received from my insurer, including any personal injury protection coverage received as a result of a liability settlement. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment and of this signature is to be considered valid. I agree to pay any deductible or other balance not paid by my insurer. I am responsible for payment in full for all fees regardless of insurance reimbursement. Payment is required after each visit for medical services unless other payment arrangements are made. I understand that a monthly charge of 1.5% (ANNUAL RATE 18%) and collection costs including attorney fees, if applicable, may be charged on overdue payments. It is our policy that patients who are younger than 18 years of age must be accompanied by their parent/guardian.

______________________________ ______________________

Patient's Signature *Date*