



Acct. # \_\_\_\_\_ Dr. # \_\_\_\_\_ Recep. \_\_\_\_\_

IF THIS APPOINTMENT IS DUE TO A WORK COMP OR ANY INJURY, PLEASE DO NOT COMPLETE THIS FORM. THE RECEPTIONIST WILL BE GLAD TO ASSIST YOU IN COMPLETING THE CORRECT INFORMATION SHEET.

We are appreciative of the individuals and companies that continue to refer to our practice. How did you hear about our practice? Age: \_\_\_\_\_
Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_
Home Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Home Phone Number: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_
Patient Information: Sex:  M  F Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_
 Widowed  Single  Married Drug Allergies: \_\_\_\_\_
Employer's Name: \_\_\_\_\_ Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_
Patient's Email Address: \_\_\_\_\_

\*\*\*\*\* POLICY HOLDER INFORMATION \*\*\*\*\*

POLICY HOLDER

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_
Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_
Employer's Name: \_\_\_\_\_ Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

TO PROVIDE THE INSURANCE COMPANY WITH THE INFORMATION NEEDED TO PROCESS YOUR CLAIM, WOULD YOU PLEASE ANSWER THE FOLLOWING QUESTIONS:

\*\*\*\*\* INSURANCE INFORMATION: PLEASE HAVE INSURANCE CARDS AVAILABLE TO COPY \*\*\*\*\*

PRIMARY Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_ Employer: \_\_\_\_\_
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F
Insurance Company Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_
PATIENT RELATIONSHIP TO INSURED
Self  Spouse  Child  Other 
City State Zip
Insurance I.D. Number \_\_\_\_\_ Group &/or Policy #: \_\_\_\_\_

SECONDARY Insurance

Check - None  or Complete: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_ Employer: \_\_\_\_\_
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F
Insurance Company Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_
PATIENT RELATIONSHIP TO INSURED
Self  Spouse  Child  Other 
City State Zip
Insurance I.D. Number \_\_\_\_\_ Group &/or Policy #: \_\_\_\_\_

OTHER Insurance

Check - None  or Complete: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_ Employer: \_\_\_\_\_
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F
Insurance Company Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_
PATIENT RELATIONSHIP TO INSURED
Self  Spouse  Child  Other 
City State Zip
Insurance I.D. Number \_\_\_\_\_ Group &/or Policy #: \_\_\_\_\_

St. Louis Orthopedic Institute does not discriminate against Race, Color, Religion, National Origin, Ancestry, Sex or Handicap. I understand I am responsible for obtaining all precertification required by my insurance company. I authorize the release of information to my insurance company, including Medicare, and my attending physician. I hereby authorize my insurance benefits to be paid directly to St. Louis Orthopedic Institute. If signed by guardian or parent for patient, this is an authorization for medical treatment of a minor.

Signed (Patient or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_