

# ACADIANA ORTHOPEDIC GROUP

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_  
LAST FIRST MIDDLE

Nickname or name you prefer being called: \_\_\_\_\_

Patient's Physical Address: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

Mailing Address: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

SS #: \_\_\_\_\_ Drivers License #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone (Cell): \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status: Married Single Divorced Widowed Separated (Please circle one)

Reason for Appointment: (Knee, ankle, shoulder, wrist, back, etc.) \_\_\_\_\_

Is this injury a result of an accident? Yes or No If yes, what type of accident? Work related Auto accident Other

Date of onset, injury, or accident \_\_\_\_\_ Referred by: \_\_\_\_\_

Have you ever been seen by any one of the Physicians in this office? YES NO

If Yes, by which Doctor? \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Patient's Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

## IF PATIENT IS A DEPENDENT

Father's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

## INSURANCE

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Phone #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

## IF YOU WERE INJURED WHILE AT WORK

Employer at time of injury: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Date of injury: \_\_\_\_\_

## AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize AOG to furnish my insurance company(s), attorney and/or workers' comp. representative information that they may request concerning my illness or injury, written or verbal.

I hereby assign AOG all money to which they are entitled for medical and/or surgical expenses. Any credit balance will be refunded to the rightful party.

I agree to pay the amount due in full at the time of services (unless prior arrangements were made) and collection/attorney fees that are added to the unpaid balance.

Signed: \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT OR PARENT / GUARDIAN

DATE