

WELCOME TO NORTHERN ROCKIES ORTHOPAEDIC SPECIALISTS

Date: \_\_\_\_\_

GUARANTOR'S INFORMATION

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Home Phone # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_, Ext. \_\_\_\_\_ Age \_\_\_\_\_
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_
Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Widow(er) \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_
Full Time Student: \_\_\_\_\_ Yes \_\_\_\_\_ No School Name: \_\_\_\_\_
Employer \_\_\_\_\_ Employer's Phone # \_\_\_\_\_
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Name of Spouse (If applicable) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_
Spouse's Employer \_\_\_\_\_ Employers Phone# \_\_\_\_\_
Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Nearest Relative/Friend (Not Living With You) \_\_\_\_\_ Phone # \_\_\_\_\_

PATIENT INFORMATION: (If Different From Guarantor's Information)

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Home Phone # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_, Ext. \_\_\_\_\_ Age \_\_\_\_\_
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_
Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Widow(er) \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_
Full Time Student: \_\_\_\_\_ Yes \_\_\_\_\_ No School Name: \_\_\_\_\_
Employer \_\_\_\_\_ Employer's Phone # \_\_\_\_\_
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

INSURANCE INFORMATION:

Type of Insurance: \_\_\_\_\_ Commercial Insurance \_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Champus \_\_\_\_\_ Private Pay \_\_\_\_\_ Other \_\_\_\_\_
\_\_\_\_\_ Worker's Comp Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_
Primary Insurance Company Name: \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_
Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_
Group # \_\_\_\_\_ ID# \_\_\_\_\_
Patient's Relationship to the Policy Holder? \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_
Secondary Insurance Company Name: \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_
Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_
Group # \_\_\_\_\_ ID# \_\_\_\_\_
Patient's Relationship to the Policy Holder? \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_

Whom May We Thank For Your Referral?

Name of Primary Care Physician: \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_
Physician's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Attorney (if applicable): \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_
Attorney's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

AUTHORIZATIONS:

I understand that as part of my healthcare, this practice originates and maintains health records & radiology films describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records & radiology films will be retained by Northern Rockies Orthopaedic Specialists even if my healthcare provider(s) leave the practice.

Signature of Patient / Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Update: \_\_\_\_\_

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or the party who accepts assignment / participates.

Signature of Patient / Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Update: \_\_\_\_\_

As the party responsible for medical decision making for the child represented in this medical record, I hereby give my consent to Northern Rockies Orthopaedic Specialists to render both emergency and non-emergency healthcare services both in and out of my physical presence.

Signature of Patient / Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Update: \_\_\_\_\_