DEMOGRAPHIC INFORMATION

"Patient information is confidential"

Date: _____

Patient Information

Please Complete Both Sides

Legal Name: _____ DOB: _____
Last First Middle Initial

Address: _____ | _____ | _____ | _____ | _____
Street Apt# City State Zip

( ) _____ ( ) _____ ( ) _____
Home Phone Work Phone Cell Phone

Email Address: _____ Sex: ❑ Female ❑ Male Social Security # _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Employer Name: _____ Occupation: _____

Insurance Co.: _____ ID#: _____

Responsible Party/Insurance Subscriber - if different from patient or is a minor

Name: _____ DOB: _____
Last First Middle Initial

Address if different than patient: _____ | _____ | _____ | _____ | _____
Street Apt# City State Zip

( ) _____ ( ) _____ ( ) _____
Home Phone Work Phone Cell Phone

Email Address: _____ Sex: ❑ Female ❑ Male Social Security # _____

Employer Name: _____

Release of Information: Others Involved in My Care:

I hearby authorize Twin Cities Orthopedics to release my protected health information to:

Name: _____

Relationship: ❑ Parents ❑ Spouse ❑ Children ❑ Other _____

REFERRAL INFORMATION:

Referred by: _____

My Primary Physician is:

Dr. _____ at _____
(clinic or group)

Twin Cities Orthopedics

Treatment Authorization: I hereby authorize the physicians at Twin Cities Orthopedics, a professional medical corporation, (TCO), or their designee(s), to treat my or the patient's condition as they deem appropriate. It is understood and agreed that the amount paid for x-rays is for examination only and the x-ray negatives will remain the property of this office, being kept on file where they may be seen at any time while the patient is at this office.

Assignment of Benefits: I hereby assign the benefits due to me under any insurance (except a disability insurance policy) to TCO as compensation for services rendered to me or to the patient. I authorize the insurance to pay benefits directly to TCO. I authorize TCO to endorse co-issued remittances for convenience in crediting benefit payments to my account.

Medicare Assignment of Benefits (if applicable): I request that payment of authorized Medicare benefits be made to me or on my behalf to TCO for any services furnished me by their practitioners. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of original.

Release of Information: Insurance Carriers, Other Providers: I hereby authorize TCO to release any information about me or the patient, including my or the patient's medical care (the "insurance"), and to my or the patient's family physician and to any other health are providers who TCO considers it appropriate to consult in the course of my or the patient's care or for the purposes of arranging future care.

Patient Signature:_____Date:_____

Spouse, Parent or Guardian Authorizing care:

_____Date:_____

EMERGNCY NOTIFICATION:

Please list the name, address and telephone of a local contact **living at a different address,** to notify in case of emergency:

Name:_____Relationship:_____

Address:_____Telephone #:_____