Date:____________

PATIENT INFORMATION

"This information is confidential"

Please Complete Both Sides

Name:____ DOB:__________________
Last First Middle Initial

Address:____
Street Apt. #

____
City State Zip County

Home Phone:________________ Work phone:__________________ Sex:___Female___Male Social Security#______________

Marital Status: Single Married Divorced Separated Widowed

Employment Status: Full time Part time None Student Retired

Employer Name:______________________________________ Occupation:____________________

Employer Address:

If patient is a minor or you are not the insured:

Name:____ DOB:_______________
Last First Middle Initial

Address if different than patient:____
Street Apt. #

____
City State Zip County

Relationship to patient:____Parent_____Spouse **Does this person carry insurance that covers the patient?____Yes ____No**

Home Phone:_________________ Work phone:___________________ Sex:___Female___Male Social Security #______________

Marital Status: Single Married Divorced Separated Widowed

Employment Status: Full time Part time None Student Retired

Employer Name:______________________________________ Occupation:____________________

Employer Address:____

Insurance information: Please show your health insurance card to the receptionist. Co-pay ☐ yes ☐ No
If you are unable to provide correct information, you will be responsible for filing claims to your insurance carrier.

Primary Insurance	Group #	Policy #	Policy Holder	Policy Holder DOB:

Insurance Company Address	City	State	Zip	Phone

Secondary Insurance	Group #	Policy #	Policy Holder	Policy Holder DOB:

Insurance Company Address	City	State	Zip	Phone

REFERRAL INFORMATION: Referred by: ____________________________________

My Primary Physician is:

Dr. ______________________________at __________________________ (clinic or group)

Twin Cities Orthopaedics

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 care providers whom 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: ____________

EMERGENCY 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 #:____________________

Release of Information: Others Involved in My Care:

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

Name: ____

Relationship: ☐ Parents ☐ Spouse ☐ Children ☐ Other ____________________________