

New \_\_\_ Update \_\_\_ New-Office \_\_\_

**ORTHO MONTANA, PSC**

Doctor: \_\_\_ Pt. # \_\_\_

Patient's Legal Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

(Leave message? Y / N)

Sex \_\_\_ Age \_\_\_ Birth date \_\_\_\_\_ SS # \_\_\_\_\_ Work Phone \_\_\_\_\_

(Leave message? Y / N)

Marital Status \_\_\_\_\_ Employment Status \_\_\_\_\_ Cell Phone \_\_\_\_\_

(Leave message? Y / N)

Employer's Name \_\_\_\_\_ Employer's Address \_\_\_\_\_

Patient's Emergency Contact \_\_\_\_\_ Birth date \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact Relation to Patient \_\_\_\_\_

Patient's Pharmacy/Location \_\_\_\_\_

Patient's Primary Care Physician \_\_\_\_\_ Patient's Referring Doctor \_\_\_\_\_

**PARENT INFO IF PATIENT IS UNDER 18 YEARS OF AGE:**

Please list all parent names, work phone for each, home address & phone number if different from patient.

\_\_\_\_\_

**BILLS SHOULD BE SENT TO:**

Relationship \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**DO YOU HAVE INSURANCE?** Yes \_\_\_ No \_\_\_ **If Yes, Name of Carrier:** \_\_\_\_\_

Insurance Card Holder Name \_\_\_\_\_ Social # of card holder: \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Birth date \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Home Address \_\_\_\_\_

**SECONDARY INSURANCE?** Yes \_\_\_ No \_\_\_ **If Yes, Name of Carrier** \_\_\_\_\_

Insurance Card Holder Name \_\_\_\_\_ Social security # of Card Holder \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Birth date \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Home Address \_\_\_\_\_

**WORKER'S COMPENSATION:**

Work Comp Insurance Company \_\_\_\_\_ Claim # \_\_\_\_\_

Injured Body Part \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employer's Name & Phone Number (at time of injury) \_\_\_\_\_

Are you working now? Yes \_\_\_ No \_\_\_ Have you filed a claim with your employer? \_\_\_\_\_

**I authorize ORTHO MONTANA to disclose medical and work status concerning my condition to my employer, case manager, and/or voc rehab; Thereby releasing the provider for any liability arising from such disclosure. Initial \_\_\_\_\_ Date \_\_\_\_\_**

**AUTO ACCIDENT INFORMATION:**

Auto Insurance Information: Date of Injury: \_\_\_\_\_ Claim # \_\_\_\_\_

Insured Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Insurance Company Name/Address/Phone \_\_\_\_\_

**AUTHORIZATION:**

**I hereby consent to treatment for myself and/or the above named minor.**

**I authorize the release of my health information to myself, to \_\_\_\_\_, and  
(name and relation to patient)**

**to my insurance company regarding my condition and treatment as necessary to process my claims. I acknowledge I am financially responsible for any non-covered services, co-pays, and deductibles. I authorize and direct all payors to pay benefits directly to Ortho Montana, PSC for services rendered to myself and/or the above named minor.**

**This shall serve as a two-year authorization unless specifically revoked in writing by the undersigned.**

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_