New Update New-Office **ORTHO MONTANA, PSC** **Dr._____ Pt. # _____**

Patient's Legal Name: _____ **Today's Date _____**

Address_____ Zip Code_____ Home Phone _____
(Leave message? **Y / N**)

Sex ____ Age _____ Birthdate _____ 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_____

E-Mail Address _____Preferred Language: _____

Race: **Ethnicity:**

___American Indian or Alaska Native ___Black or African American ___Other ___Hispanic or Latino

___Asian ___Native Hawaiian or Pacific Islander ___White ___Other

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: Injured Body Part_____
Auto Insurance Information: Date of Injury: _____ Claim # _____
Insured Name: _____ Phone Number _____
Insurance Company Name/Address/Phone _____

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 _____

AUTHORIZATION:

I authorize the release of my health information to myself or the above named minor to the following individual(s), _____, 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 payers 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.

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

SIGNED _____DATE_____