LAKESIDE ORTHOPEDIC INSTITUTE

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Patient's Name: _____
LAST FIRST M.I.

Permanent Address: _____
STREET CITY STATE ZIP

Winter Address: _____
STREET CITY STATE ZIP

Marital Status: _____ Sex: M / F Employer: _____

Employer Address _____
STREET CITY STATE ZIP

Home Phone#: _____ Cell Phone#: _____ Work Phone #: _____

Date of Birth: _____ Age: _____ Social Security #: _____
MO DAY YEAR

Contact In Case of Emergency: _____ Relationship _____ Phone: _____

Primary Physician: _____ Phone: _____
NAME STREET CITY STATE ZIP

INSURANCE INFORMATION **THIS PORTION MUST BE FILLED OUT COMPLETELY**

Primary Insurance: _____ Phone#: _____
NAME CLAIMS ADDRESS CITY STATE ZIP

Group Number: _____ ID#: _____ **Copay**: $_____

Guarantor Name: _____ Relation to Patient: _____ Date of Birth: _____

Secondary Insurance: _____ Phone#: _____
NAME CLAIMS ADDRESS CITY STATE ZIP

Group Number: _____ ID#: _____ **Copay** $: _____

Guarantor Name: _____ Relation to Patient: _____ Date of Birth: _____

Are you being seen for an injury?: Yes / No Is the injury work related?: Yes / No Motor Vehicle Related?: Yes / No

Date of Accident: _____ Date First Treated: _____ Where: _____
MO DAY YEAR MO DAY YEAR

Industrial Ins Co: _____ Phone#: _____
NAME CLAIMS ADDRESS CITY STATE ZIP

Policy/Case#: _____ Adjusters Name: _____ Phone#: _____

PAYMENT POLICY AUTHORIZATION:

Payment is due at the time of service, unless prior arrangements have been made with this office. I authorize my treating physician to release my medical records to my physician, to the medical provider who referred me and to the medical providers you may refer me to or consult with on my behalf. I authorize to release any medical information necessary for processing insurance claims. I hereby authorize assignment of my insurance benefits to you and I agree to promptly pay amounts not covered by them. I certify that the above information is correct.

_____ _____ _____
PATIENT OR GUARDIAN'S SIGNATURE PLEASE PRINT PATIENT/GUARDIAN NAME DATE