LAKESIDE ORTHOPEDIC INSTITUTE LLC

Preferred Pharmacy: ______________________
How did you hear about us?: ____
Last Name: ______________________________________ First Name: ________________________________ MI: ___
Nick Name: ____________________ Maiden Name: ______________ Prefix: _____ Suffix: ____Credentials: ________
Date of Birth: ____________ Gender: M F SSN# __________________ Driver's License# ____________________
Race: White__ Black/African American__ Asian__ Unknown__ Declined__ Other________________________
Marital Status: Married__ Single__ Separated__ Divorced__ Widowed__ Other__ Unknown__
Primary Language: English__ Spanish__ Other____
Ethnicity: Not Hispanic/Latino__ Hispanic/Latino__ Unknown__ Declined__

Address: ____

Zip_________________City **LHC**: ___________________State: **AZ** _____County: __________ Country: **USA** _________

Home Phone: _____________ Work Phone: ______________Cell Phone:__________Primary Phone:_______________

Fax: ____________________ Pager: ____________________ E-Mail: ____

Primary Insurance
Name/Address: ____

Phone #: ______________________ Group#: ____________________ ID#: _____________________ Copay$________
Policy Holder Information:
Last Name: __________________________________ First Name: _______________________________ MI: ________
SSN# ______________________ Date of Birth: _______________ Gender: M F Home Phone:______________ Work Phone:______________
Employer Name/Address: ____

Secondary Insurance
Name/Address: ____

Phone# : ___________________________ Group#: _________________________ ID#: __________________________

Emergency Contact: _______________________________ Relationship: ____________ Phone:____________________

Primary Physician: _____________________________________ Phone: ______________________________________

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 1st Treated:________________ Where?________________________________
Industrial Carrier: ____Phone#: ________________________

Policy/Case#: ___________________ Adjusters Name: _____________________Phone#: ________________________

PAYMENT POLICY AUTHORIZATION:

Payment is due at the time of service, unless 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 on my behalf. I authorize release of 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/Guardian Signature: ____ Date: ______________________
Please Print Patient/Guardian Name: ____ Relationship to Patient ______________________