



THE SHOULDER CLINIC
OF IDAHO P.L.L.C.

Patient Information

Patient's Last Name _____ First _____ Middle _____ F _____ M _____
 Home Address _____ City _____ State _____ Zip _____
 Patient's Social Security No. _____ Home Phone _____ Cell Phone _____ Work Phone _____
 Age _____ Date of Birth _____ Single _____ Married _____ Divorced _____ Widowed _____
 Patient's Employer _____ Years with Firm _____ Occupation _____
 Spouse's Name _____ Employer _____ Work Phone _____
 Spouse's Social Security No. _____ Occupation _____
 Nearest Relative _____ Relationship _____ Phone _____
 Family Physician _____ Referred By _____
 Whom May We Contact in Case of Emergency? _____ Phone _____
 Father's Name (IF MINOR) _____ Employer _____ Work Phone _____
 Father's Social Security No. _____ Occupation _____
 Mother's Name (IF MINOR) _____ Employer _____ Work Phone _____
 Mother's Social Security No. _____ Occupation _____

Insurance Information

Date of accident/injury or onset of symptoms _____
 Brief Description: _____
PRIMARY INSURANCE COMPANY NAME _____
 Patient Relationship to Subscriber. Please circle one. (self, spouse, child) _____ Date of Birth _____
 I.D. No. _____ Group No. _____
SECONDARY INSURANCE COMPANY NAME _____
 Patient Relationship to Subscriber. Please circle one. (self, spouse, child) _____ Date of Birth _____
 I.D. No. _____ Group No. _____

Please Read & Sign Below

Recognizing the inherent risks of transmission of contagious diseases, especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc., when deemed necessary by physician. Questions should be discussed with your physician. I hereby authorize the doctors of THE SHOULDER CLINIC OF IDAHO to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expense relating to the services performed from time to time, but not to exceed my indebtedness to said physicians and surgeons. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me or, in the proper case, to my employer or other provider of insurance, when my bill is paid in full. I understand I am financially responsible to said doctors for charges not covered by this assignment. I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files, and authorize the insurance company to accept the photocopy. I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

I understand that the providers of THE SHOULDER CLINIC OF IDAHO do not treat worker's compensation or liability case claims and attest that my visit to the clinic is not related to either of these.

Affiliation with Treasure Valley Hospital

Please be advised that Dr. Goodwin and Dr. Chopp have limited partnership-ownership in Treasure Valley Hospital in Boise. We feel proud of the high quality of care this facility provides our patients

There are several medical facilities that are available for your radiographic imaging needs (i.e. MRI scans), and surgical procedures including Treasure Valley Hospital.

Please feel free to discuss this at any time with Dr. Goodwin or Dr. Chopp.

_____ Date _____
 RESPONSIBLE PARTY'S SIGNATURE