



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 _____

Insurance Co. Address _____

Insurance Co. Phone _____ Subscriber Name _____ Date of Birth _____

Patient Relationship to Subscriber. Please circle one. (self, spouse, child)

I.D. No. _____ Group No. _____

SECONDARY INSURANCE COMPANY NAME _____

Insurance Co. Address _____

Insurance Co. Phone _____ Subscriber Name _____ Date of Birth _____

Patient Relationship to Subscriber. Please circle one. (self, spouse, child)

I.D. No. _____ Group No. _____

DOES YOUR INSURANCE COMPANY REQUIRE A SECOND OPINION? Yes _____ No _____

DOES YOUR INSURANCE COMPANY REQUIRE PRE-AUTHORIZATION FOR SURGERY AND/OR ADMISSION? Yes _____ 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.

_____ Date

RESPONSIBLE PARTY'S SIGNATURE