ALBRACHT
ORTHOPEDIC SURGERY

Today's Date: _______________ Who referred you to our office? ____________________

PATIENT INFORMATION **-- email address, required by new healthcare laws: ____________________**

Name: Last ____________________ First ____________________ Middle ____________

Mailing Address: Street ____________________ Apt. ____ City, State ____________________ Zip ________

Phone Numbers: Home ____________________ Work ____________________ Cell ____________________

Age: ____ Date of Birth: ____________ Patient's SS#: ____________________ Gender: M or F Marital Status: M S W D

Patient's Employer/School: ____________________ Occupation/Grade: ____________________

Emergency Contact (not living w/you): ____________________ Relationship to Patient: ____________________

Emergency Contact Phone Numbers: ____________________

SPOUSE or PARENT/GUARDIAN INFORMATION (if minor)

Name: Last ____________________ First ____________________ Middle ____________

Mailing Address: Street ____________________ Apt. ____ City, State ____________________ Zip ________

Phone Numbers: Home ____________________ Work ____________________ Cell ____________________

Date of Birth: ____________ SS#: ____________________ Gender: M or F Relationship to Patient: ____________________

Marital Status: M S W D Employer: ____________________ Occupation: ____________________

RESPONSIBLE PARTY INFORMATION (if other than patient or parent accompanying a minor today)

Name: Last ____________________ First ____________________ Middle ____________

Mailing Address: Street ____________________ Apt. ____ City, State ____________________ Zip ________

Phone Numbers: Home ____________________ Work ____________________ Cell ____________________

Date of Birth: ____________ SS#: ____________________ Gender: M or F Relationship to Patient: ____________________

Marital Status: M S W D Employer: ____________________ Occupation: ____________________

PRIMARY INSURANCE NAME: ____________________ Member ID: ____________________

Group Number: ______________ Policy Holder Name: ____________________ Policy Holder Date of Birth: ____________

Policy Holder SS#: ______________ Relation to Patient: ______________ Employer: ____________________

SECONDARY INSURANCE NAME: ____________________ Member ID: ____________________

Group Number: ______________ Policy Holder Name: ____________________ Policy Holder Date of Birth: ____________

Policy Holder SS#: ______________ Relation to Patient: ______________ Employer: ____________________

If Workers' Comp: Date of Injury: ____________________ Claim Number: ____________________

Adjuster's Name: ____________________ Adjuster's Phone Number: ____________________

- I hereby authorize my insurance benefits to be paid directly to Albracht Orthopedic Surgery.
- I acknowledge that payment is expected at the time of service for charges not covered by my insurance including office visit co-pays, co-insurance, and deductibles. I am financially responsible for any unpaid balance due to out of network penalties.
- I authorize the release of any information requested by my insurance company.

Authorized Signature: ____________________ Date: ______________

PLEASE BRING THIS FORM ALONG WITH YOUR INSURANCE CARD(S) AND APPLICABLE CO-PAY(S) TO YOUR APPOINTMENT.