PATIENT INFORMATION SHEET

Welcome to Cornerstone Orthopedics!

This form must be filled out completely to the best of your knowledge

I. Patient Information

Last Name: ________________________________ First Name:__________________________ Middle Initial:________

Social Security #: _____-_____-______ Birth Date (Month/Day/Year): ____/____/______ Sex: F M (Circle One)

Address:____ Apt #:___________ City:______________________________

State:_________ Zip: _________________ Home phone: (______) _______-____________

Work phone: (______) _______-__________ ext:_______ Cell phone: (______) _______-____________

Email Address: ____ Occupation: ___________________________________

Employer: ____ Employer Phone Number: (______) ______-___________

Emergency Contact Name: ____________________________________ Phone Number: (______)______-__________

Preferred Language: _______________________

Race: Please check one:
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander
☐ White/Caucasian ☐ Choose to not report

Ethnicity: Please check one:
☐ Hispanic or Latino ☐ Non-Hispanic ☐ Choose to not report

II. Today's Visit

Reason for visit: ____ Date of Injury/Onset of Symptoms: __________

How were you referred to us?:______________________________ Referring Physician: ____________________________

Primary Care Physician (PCP): _________________________ PCP's Phone Number: (______)________-____________

III. Insurance Information

Primary Insurance: ___________________________________ Secondary Insurance: _______________________________

Is your injury work or auto related? If no, continue to section IV.

If yes, (Circle One) Workman's Comp Auto- State Accident Occurred_________

Claim #: ____ Date of Injury_________________

Adjuster Name: __________________________________ Adjuster Phone #: (_____) ______-_________ ext: __________

Workerman's Comp Physician: ____________________________ Phone # (____) _______-__________

Please Complete Reverse Side

IV. PRIMARY Policy Holder (Guarantor)

(For insurance billing purposes, we require the name, date of birth, address if different than the patient and employer name and phone number of the **person who is considered the insured**. This person is not always the patient and could be a spouse, parent or another person).

Guarantor Last Name:______________________________ First Name: ___________________ Middle Initial:_______

Guarantor Sex: F M (Circle One) Relationship to patient:_____________________________________

Address (if different from patient): ____ Apt #: _________

City: _______________________________ State: _______ Zip: _____________

Guarantor Phone Number: (______) ______-_________ Guarantor Date of Birth: _____/_____/_______

Guarantor Social Security # : _____-_____-________ Guarantor Employer Name:________________________________

Employer Phone Number: (______) ______-__________

V. SECONDARY Policy Holder (Guarantor) – If Applicable

(For insurance billing purposes, we require the name, date of birth, address if different than the patient and employer name and phone number of the **person who is considered the insured**. This person is not always the patient and could be a spouse, parent or another person).

Guarantor Last Name: ______________________________ First Name: ___________________ Middle Initial:_______

Guarantor Sex: F M (Circle One) Relationship to patient: _____________________________________

Address (if different from patient): ____ Apt #: _________

City: _______________________________ State: _______ Zip: _____________

Guarantor Phone Number: (______) ______-_________ Guarantor Date of Birth: _____/_____/_______

Guarantor Social Security #: _____-_____-________ Guarantor Employer Name:________________________________

Employer Phone Number: (______) ______-__________

Authorization to Pay Benefits/Release Information

I hereby authorize payment directly to the Physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay for all non-covered services. I also hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Print Patient Name: ____

Signature: ____ Date: ____________________

(If patient is under 18, the parent or guardian must sign)

Please Complete Reverse Side