

PONTCHARTRAIN BONE AND JOINT CLINIC, LTD.

PATIENT INFORMATION

(PLEASE PRINT LEGIBLY - MEDICAL RECORDS DATA)

PATIENT'S NAME: (LAST FIRST MIDDLE)			DATE OF BIRTH	AGE	MARITAL STATUS S M W D SEP	SEX F M	SOCIAL SECURITY NO.	
STREET ADDRESS				CITY AND STATE			ZIP CODE	HOME PHONE
PATIENT'S EMPLOYER				OCCUPATION (INDICATE IF STUDENT)			HOW LONG	WORK PHONE
DRUG ALLERGIES							CELL PHONE	
REFERRED BY:				PRIMARY CARE PHYSICIAN:				
SPOUSE'S NAME			EMPLOYER			WORK #		
FATHER'S NAME			EMPLOYER			WORK #		
MOTHER'S NAME			EMPLOYER			WORK #		
PERSON TO NOTIFY IN CASE OF EMERGENCY				RELATIONSHIP			WORK / HOME #	
DATE OF INJURY	WAS AN AUTOMOBILE INVOLVED?	WERE YOU INJURED ON THE JOB?	EMPLOYER AT TIME OF INJURY					
WERE X-RAYS TAKEN OF THIS PROBLEM? YES NO		WHERE?				DATE X-RAYS TAKEN		
PARTY RESPONSIBLE FOR PAYMENT		D.O.B. / /	ADDRESS, STREET, CITY & ZIP CODE				PHONE #	
PRIMARY INSURANCE COMPANY			POLICY HOLDER'S NAME			SOCIAL SECURITY NO.		
OTHER INSURANCE COMPANY			POLICY HOLDER'S NAME			SOCIAL SECURITY NO.		
OFFICE USE ONLY								

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Pontchartrain Bone and Joint Clinic, Ltd. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

Certain physician members of Pontchartrain Bone and Joint Clinic have an ownership interest in either East Bank Imaging, St. Charles Surgical Hospital or Greater New Orleans Surgery Center. These physicians have become owners as a result of their commitment to quality health care and to assure proper service to their patients. I understand that my physician may have an ownership interest in a facility to which I may be referred and that I have the right to obtain medical services at a facility of my choice.

Date: _____ **Signature** _____