

DATE _____

GEM CITY BONE & JOINT

PATIENT INFORMATION

LAST _____ FIRST _____ M _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
SOCIAL SECURITY NO. _____ DOB _____ AGE _____ SEX _____
EMPLOYER _____ OCCUPATION _____
MARITAL STATUS _____ SPOUSE'S NAME _____
ALTERNATE CONTACT _____ PHONE _____
RELATIONSHIP TO PATIENT _____
E-MAIL ADDRESS _____ DO YOU SMOKE? _____

BILLING INFORMATION - PERSON RESPONSIBLE FOR PAYMENT

LAST _____ FIRST _____ M _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
EMPLOYER _____ ADDRESS _____
RELATIONSHIP TO PATIENT _____

PRIMARY INSURANCE

INSURANCE COMPANY _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
WC NUMBER _____ T-19 NUMBER _____
POLICY HOLDER'S NAME _____ EMPLOYER _____
SOCIAL SECURITY NO. _____ DOB _____
POLICY NUMBER _____ GROUP NUMBER _____
PHONE NUMBER _____

SECONDARY INSURANCE

INSURANCE COMPANY _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
POLICY HOLDER'S NAME _____ EMPLOYER _____
SOCIAL SECURITY NO. _____ DOB _____
POLICY NUMBER _____ GROUP NUMBER _____
PHONE NUMBER _____

MEDICAL INFORMATION

REASON FOR TODAY'S VISIT _____
SYMPTOMS _____
DATE OF INJURY _____ LOCATION _____
HOW DID ACCIDENT OCCUR? _____
WHERE DID YOU HEAR ABOUT US? _____
ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ IF SO, WHAT? _____