

FRONT RANGE ORTHOPEDIC CENTER • PATIENT INFORMATION

Today's Date _____ Family Doctor _____ ID Verified _____

PATIENT (Legal Name) _____

Patient Address _____

Home Phone _____ Cell # _____ Date of Birth _____ Age _____

Patient's Social Security Number: _____ - _____ - _____ Male _____ Female _____

Marital Status: S M W D

How did you learn about Front Range Orthopedic Center (please indicate all that apply)

Referral from Doctor. Dr. _____ referred me.

Referred by my family member or friend

Reputation in the community

Website

Insurance

Advertisement

Other, please list _____

Emergency Contact _____ Relationship to Patient _____ Phone _____

If patient is under 21 give name and address of parents

Name _____ Address _____

Parent's Social Security Number _____ - _____ - _____

EMPLOYMENT STATUS OF PATIENT OR PARENTS

Employer _____ Phone _____

INSURANCE INFORMATION: _____ INDICATE IF NONE: _____

Primary Insurance Co _____ Subscriber # _____

Insurance Co Address _____ Group # _____

Policy Holder's Name _____ Date of Birth _____ Male _____ Female _____

Policy Holder's SS# _____ - _____ - _____ Employer _____

Secondary Insurance Co _____ Subscriber # _____

Insurance Co Address _____ Group # _____

Policy Holder's Name _____ Date of Birth _____ Male _____ Female _____

Policy Holder's SS# _____ - _____ - _____ Employer _____

I hereby assign to this medical practice all monies to which I am entitled for medical and/or surgical expense relative to the service rendered by this practice, but not to exceed my indebtedness to said medical practice. It is understood that any monies received from the above named insurance company(s), over and above my indebtedness, will be refunded to me or my insurance company(s), as is determined to be appropriate, when my bill is paid in full. I understand I am financially responsible to said medical practice for charges not covered by this assignment.

Disability Forms: In the event that I require that disability forms be completed on my behalf, I request FROC, PC to disclose any & all information to persons who administer claims for disability purposes used for evaluating & administering my claims benefits, which may include assisting me in returning to work. **I understand that FROC, P.C. charges \$20.00 for the completion of each disability form and that this fee is to be paid in advance.** The average time of completion of disability forms is 10 - 14 working days.

INSURED OR
GUARDIAN'S SIGNATURE _____

PATIENT'S
SIGNATURE _____