DATE _____ HISTORY _____

BLUE RIDGE BONE & JOINT CLINIC, P.A.

CODE_____ DOCTOR _____

PATIENT INSURANCE INFORMATION WORKSHEET

PLEASE COMPLETE ALL OF THE REQUESTED INFORMATION

Patient Name: _____ _____
Last First Middle Home Phone

Mailing Address: _____
Street Name or PO Box City State Zip Code

_ Male _ Female / / _____
Sex Birthdate Age Social Security Number

_____
Parent / Legal Guardian Social Security Number

_____
Patient or Parent's Employer Occupation

_____
Employer Address Work Phone #

_____
Marital Status Spouse's Name Spouse's Employer Phone Number

Name of Insurance	*Address*	*Policy Holder*	*SSN / Cert#*	*Date of Birth*	*Group #*	*Is the following Required?*
FIRST:				____/_____/____ Month Day Yr		_PRE-CERTIFICATION _SECOND OPINION
SECOND:				____/_____/____ Month Day Yr		_PRE-CERTIFICATION _SECOND OPINION
THIRD:				___/_____/____ Month Day Yr		_PRE-CERTIFICATION _SECOND OPINION

Were you referred by another physician?_____
Physician's Name (first & last) Address

Have you been treated by any of our Physicians before? (in the Office or in the Hospital) _Yes _No

If yes, which Doctor?_____ **When? (date)**_____

Name of Contact in Case of Emergency_____ **Phone Number**_____

___ _yes _ no _____
Were you injured at work? Name of Contact to Verify Your Claim? Phone Number

Address for Mailing Your Claim?_____

_____

We request payment at the time of service for office charges.
I consent to treatment at Blue Ridge Bone & Joint and Blue Ridge Physical Therapy Center, and release of information for insurance purposes and assignment of benefits on insurance filed on unpaid services.

Patient's Signature:_____
(Or Patient's Representative Signature)