

**Patient** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SSN** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ ext \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **SSN** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
Address (if different) \_\_\_\_\_ Employer \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext \_\_\_\_\_ Cell Phone \_\_\_\_\_

As a courtesy, we bill your medical insurance. All co-insurance and co-pays are due at time of service, unless prior financial arrangements have been made with our credit department.

**Primary Insurance** \_\_\_\_\_ **Policy** \_\_\_\_\_ **Group** \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
Address if different from patient \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ **Policy** \_\_\_\_\_ **Group** \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
Address if different from patient \_\_\_\_\_

**Third Insurance** \_\_\_\_\_ **Policy** \_\_\_\_\_ **Group** \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
Address if different from patient \_\_\_\_\_

	<b>YES</b>	<b>NO</b>
<b>IS THIS AN ON THE JOB INJURY*</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>AUTO ACCIDENT**</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OR OTHER LIABILITY INJURY**</b>	<input type="checkbox"/>	<input type="checkbox"/>

\*If work related please complete 827 form.  
\*\*If auto or other accident please complete accident form.

I authorize Klamath Orthopedic to disclose medical and/or billing information on my behalf to the friends/family listed below. Klamath Orthopedic will not release any information to parties not listed on this written consent.

**Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relation** \_\_\_\_\_  
\_\_\_\_ **Medical Information** \_\_\_\_ **Billing Information** \_\_\_\_ **Emergency contact**

**Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relation** \_\_\_\_\_  
\_\_\_\_ **Medical Information** \_\_\_\_ **Billing Information** \_\_\_\_ **Emergency contact**

**Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relation** \_\_\_\_\_  
\_\_\_\_ **Medical Information** \_\_\_\_ **Billing Information** \_\_\_\_ **Emergency contact**

I have been provided with HIPAA guidelines and Federal Red Flag Rules.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_