PATIENT INFORMATION FORM

WISCONSIN RIVER ORTHOPAEDICS

Date _____

Last Name _____ **First Name** _____ **Middle Initial** _____

Suffix _____ Prefix _____ Nickname/preferred name _____

Previous Name_____ **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number _____ **Date of Birth** _____

Sex ☐ Male ☐ Female ☐ Other **Ethnic Group** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other _____

Race _____ **Language** _____

Primary Care Physician _____ **Referring Physician** _____

Contact Information

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Preferred Phone ☐ Home ☐ Cell Is It Ok to leave a detailed message? * ☐ Yes ☐ No

Email Address _____

Street Address _____

City _____ **State** _____ **Zip** _____ **County** _____

Emergency Contact Full Name _____ **Relation** _____ **Phone** _____

Spouse Full Name _____ **Phone** _____

Employment Information

Employer's Name _____ **Employment Status** ☐ Full Time ☐ Part time ☐ Retired

Do you have insurance? ☐ Yes ☐ No **If not, how do you intend to pay?** ☐ Cash ☐ Check ☐ Visa/MC

Primary Insurance – copy required

Insurance Name _____

Address_____

Policy # _____

Group # _____

Employer _____

_____

(Policy holder name/date of birth)

Secondary Insurance – copy required

Insurance Name _____

Address _____

Policy #_____

Group #_____

Employer _____

_____

(Policy holder name/date of birth)

Person Financially Responsible for the Bill (if the above patient is a minor)

Name _____ Date of Birth _____ Social Security # _____

Address (if different) _____

Father's Employer _____ Employer Phone _____

Mother's Employer _____ Employer Phone _____

Workers Compensation Information

Date of injury/first report _____

Claim # _____

Employer _____

Contact Person _____

Type of injury _____

Name of WC Company _____

Address _____

Injury/ Accident Information

Accident Date _____ Place _____

Type of Accident _____

Accident Details _____

_____

Will you be billing a liability or third-party carrier? ☐ Yes ☐ No

Name of Carrier _____

Address _____