

DR \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_ CHART# \_\_\_\_\_

PATIENT INFORMATION

RESPONSIBLE PARTY

INSURANCE

SIGNATURES

NAME LAST FIRST MIDDLE			BIRTH DATE	AGE	SS #
STREET ADDRESS			HOME PHONE ( )	WORK PHONE ( )	
CITY STATE ZIP CODE		MARITAL STATUS		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
EMPLOYER			REFERRING PHYSICIAN - (CHECK BOX IF REFERRED BY E R DOCTOR <input type="checkbox"/> )		
ADDRESS			ADDRESS		
CITY STATE ZIP CODE		FAMILY PHYSICIAN			
X-RAYS/TESTS <input type="checkbox"/> YES <input type="checkbox"/> NO	X-RAYS/TESTS TAKEN AT	DATE DONE	X-RAYS/TESTS WITH PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGIES TO MEDICATIONS / MEDICAL CONDITIONS	
ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT DATE	ACCIDENT OCCURRED <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER		REASON FOR SEEING DOCTOR	
ATTY INVOLVED <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, ATTORNEYS NAME AND PHONE NUMBER			

NAME		EMPLOYER	
ADDRESS		ADDRESS	
CITY, STATE ZIP CODE		CITY, STATE	
RELATION TO PATIENT		WORK PHONE	ZIP CODE
HOME PHONE		<b>MUST COMPLETE: IN CASE OF EMERGENCY (NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU)</b>	
SOCIAL SECURITY NUMBER		PHONE	RELATIONSHIP

INSURANCE (Please check one):  
 No Coverage  Blue Shield  HMO  TriCare  PPO  Workman's Comp.  AUTO INSURANCE  Medicare  Medicaid  Other

<b>PRIMARY COMPANY</b>		<b>SECONDARY COMPANY</b>	
ADDRESS		ADDRESS	
CITY, STATE ZIP CODE		CITY, STATE ZIP CODE	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
POLICY #		POLICY #	
ID #	GROUP #	ID #	GROUP #
RELATION TO PATIENT		RELATION TO PATIENT	

**ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF MEDICAL INFORMATION**

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby assign insurance payment directly to Kansas Joint and Spine Institute, Chartered, for the medical and/or surgical benefits, if any, otherwise payable to me, for services as described, but not to exceed my indebtedness to Kansas Joint and Spine Institute, Chartered, for those services.

**MEDICAL INFORMATION RELEASE AUTHORIZATION:** I hereby authorize Kansas Joint and Spine Institute, Chartered to release any information acquired in the course of my examination or treatment to my referring and/or family doctor, and/or my insurance company (including employer, for Workers' Compensation medical/surgical services). I will refer to the **Notice of Privacy Practices for Protected Health Information** provided me for other possible usage of my protected health information.

**FINANCIAL AGREEMENT:** I understand that I am ultimately responsible for all fees, regardless of insurance coverage.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_  
 (except, if a minor)

INSURED'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 (if other than patient)