Patient Information

Name _____ SSN _____

Date of Birth _____ Sex M / F Married / Single / Divorced / Widowed

Mailing Address _____ City/State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Primary Care Doctor/Clinic_____

Occupation _____ Employer _____

Emergency Contact Name _____ Phone _____

Insurance Information

Do you have: Medical Insurance - Yes / No

- Primary Insurance _____ Policy Holder _____ DOB _____

  Policy Number _____ Group Number _____

- Secondary Insurance _____ Policy Holder _____ DOB _____

  Policy Number _____ Group Number _____

Mailing address / phone number of Policy Holder, if different than above _____

_____

Worker's Compensation

Is this a Worker's Comp Injury - Yes / No Date of Injury _____

WC Insurance Carrier _____ Adjustor _____

Claim Number _____ Phone _____

Authorization

I, the undersigned, have insurance, and assign directly to Juneau Bone & Joint Center all medical benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize JBJC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed _____ Date _____