☐ Nicola ☐ Smith
☐ Hansen ☐ Wolf
☐ Daines

Account # ______________________

Date ______________________

Reason for treatment__________________________ Date of injury or 1st symptom _____/______/_____ ___ Left ___ Right

Patient's Legal Name: Last______________First______________Middle______________ ____ Male ____ Female

Mailing Address ______________________ City______________ State _________ Zip_______________

Home Phone ______________ Cell/Pager______________ DOB____________ Age_______ Marital Status (check one)

SS#______________ Work Phone______________ (extension)___________ M___S___D___W___

Patient's Employer:______________ How Long?_____________ Occupation______________

Spouse's Name______________DOB______________ Employer______________

Spouse's SS#______________Work Phone______________ Occupation______________

Can we contact you by e-mail? __Yes __No E-mail______________

Patient's Legal Guardian:______________

Father's Name (IF MINOR)______________SS#______________DOB______________

Father's Home Address______________City______________State_______Zip______________

Father's Employer______________Occupation______________Work Phone______________

Mother's Name (IF MINOR)______________SS#______________DOB______________

Mother's Home Address______________City______________State_______Zip______________

Mother's Employer______________Occupation______________Work Phone______________

Whom may we contact in case of emergency?______________

Relationship______________ Phone______________

Who referred you to our practice? ___Yellow pages ___Family/friend ____ER ____Physician (please see note below)

Primary Care or Referring Physician______________ Date Last Seen____________ Have you had any of the following procedures in regard to this injury? ___X-ray __MRI __CT scan __Bone Density - Where______________

PRIMARY INSURANCE COMPANY NAME______________ Phone______________

Insurance Co. Address______________

Relationship to Subscriber

Subscriber Name______________ *___Self ___Spouse ___Child ___Step-parent ___Other*

Subscriber DOB:______________ ID #______________ Group #______________

SECONDARY INSURANCE COMPANY NAME______________ Phone______________

Insurance Co. Address______________

Relationship to Subscriber

Subscriber Name______________ *___Self ___Spouse ___Child ___Step-parent ___Other*

Subscriber DOB:______________ ID #______________ Group #______________

Motor Vehicle Accident ___Yes ___No	**Attorney Involved** ___Yes____No	**State**	**Attorney Name, Address & Phone**

Work-Related Injury ___Yes ___No	**Date of Injury, or 1st symptom** _____/_____/_____	**Have you notified your employer of your injury?** ___Yes ___No	**Worker's Comp Claim #**	**Employer at time of injury**	**Employer phone #**

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:
I directly assign all medical/surgical benefits to West Idaho Orthopedics and Sports Medicine and understand that I am financially responsible for all charges, whether or not paid for Insurance. I hereby authorize West Idaho Orthopedics and Sports Medicine to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

I, the undersigned, acknowledge receipt of a copy of West Idaho Orthopedics and Sports Medicine Notice of Privacy Practice. A copy will be available at our office(s).

Patient/Legal Guardian Signature______________ **Date**______________