



LEBANON ORTHOPAEDIC ASSOCIATES

INFORMATION FORM

PATIENT:

Name: Last _____ First _____ MI _____

Maiden Name: _____

Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Birth Date: _____ SS# _____

Employer/School: _____ Work Phone: _____ Ext: _____

Address: _____ Dept. _____

City/State/Zip: _____

Employment Status: Full Time: _____ Part Time: _____ Retired: _____

Sex: _____ Marital Status: _____ Age: _____ Race: _____

Responsible Party (if under 18): _____

Spouse's Name: Last _____ First _____ MI _____

Contact Person: _____

PRIMARY INSURED: SELF/SPOUSE/PARENT

Name: Last _____ First _____ MI _____

Address: _____

City/State/Zip: _____

Birth Date: _____ Age: _____ Sex: _____ SS# _____ Marital Status: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Employer/School: _____

Address: _____

City/State/Zip: _____

SECONDARY INSURED: SELF/SPOUSE/PARENT

Name: Last _____ First _____ MI _____

Address: _____

City/State/Zip: _____

Birth Date: _____ Age: _____ Sex: _____ SS# _____ Marital Status: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Employer/School: _____

Address: _____

City/State/Zip: _____

OFFICE VISIT:

Is this visit related to an accident: _____ NO _____ YES

If yes, is this accident related to:

Work: _____ NO _____ YES Date: _____

Auto: _____ NO _____ YES Date: _____ State: _____

Other: _____ NO _____ YES Date: _____

First day/date unable to work: _____

***PLEASE TURN PAGE OVER TO PROVIDE INSURANCE INFORMATION AND SIGN RELEASES

INSURANCE:

Primary insurance to bill: _____

Address: _____

Policy #: _____ Group #: _____

Insured: ___ Patient ___ Spouse ___ Other (name): _____

Other insurance: _____

Address: _____

Policy #: _____ Group #: _____

Insured: ___ Patient ___ Spouse ___ Other (name): _____

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND RESPONSIBILITY FOR PAYMENT

I authorize Lebanon Orthopaedic Associates, and their personnel to accept this signature on file as authorization to submit medical claims to my insurance company (s), and for the benefits to be paid directly to the physician. My signature also authorizes Lebanon Orthopaedic Associates to disclose information about me and the medical treatment that I received to my insurance company to facilitate payment of all or part of my medical bill. I agree to pay Lebanon Orthopaedic Associates for any services rendered that are not paid.

Signature of Patient

Date

Signature-Authorized Party

Signature of Patient

Date

Signature-Authorized Party

Signature of Patient

Date

Signature-Authorized Party

PAYMENT OF MEDICARE BENEFITS

I certify that the information given by me to Lebanon Orthopaedic Associates to bill Medicare is correct. I authorize and assign payment of all benefits to Lebanon Orthopaedic Associates for covered services.

Signature of Patient

Date

Signature of Patient

Date

Signature of Patient

Date