



ORTHOPEDIC PHYSICIANS
ANCHORAGE

PATIENT INFORMATION

NAME: _____ BIRTH DATE: ____/____/____
(LAST) (FIRST) (MIDDLE)

SOCIAL SECURITY NUMBER: _____ - _____ - _____ AGE: _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: _____ - _____ WORK: _____ - _____ MESSAGE: _____ - _____

EMPLOYER: _____ OCCUPATION: _____

SPOUSE/PARENT INFORMATION

NAME OF SPOUSE OR CUSTODIAL PARENT: _____

DAYTIME PHONE NUMBER: _____ - _____ RELATIONSHIP: _____

IN THE EVENT WE ARE UNABLE TO CONTACT YOU BY PHONE, MAY WE LEAVE MESSAGES REGARDING APPOINTMENTS OR EMERGENCY INFORMATION WITH THIS PERSON? YES / NO

INSURANCE INFORMATION

COMPANY OR AGENCY YOU WISH US TO BILL: _____

INJURY IS THE RESULT OF:
AUTO ACCIDENT / WORK / NO ASSOCIATED INJURY / OTHER: _____

DATE INJURY OCCURRED: ____/____/____

I UNDERSTAND THAT MEDICAL INFORMATION, (SUCH AS DIAGNOSIS, DATE OF TREATMENT, ETC.) REGARDING MY TREATMENT WILL BE FORWARDED TO THE THIRD PARTY PAYOR LISTED. I UNDERSTAND THAT THIS IS NOT A GUARANTEE OF PAYMENT. (INITIAL HERE) _____

I UNDERSTAND THAT MY PRIVATE INSURANCE WILL BE BILLED AS A COURTESY. IF, FOR ANY REASON, PAYMENT IS NOT RECEIVED WITHIN 60 DAYS OF THE APPOINTMENT DATE, I UNDERSTAND THAT I WILL BE ASKED TO FORWARD PAYMENT IN FULL. I ALSO UNDERSTAND THAT SHOULD THIS DEBT BECOME DELINQUENT, THE BALANCE MAY BE REFERRED TO A PRIVATE COLLECTION AGENCY. INFORMATION FORWARDED TO THE AGENCY WILL INCLUDE THE DATE(S) OF SERVICE, MY ADDRESS AND PHONE NUMBERS, AS WELL AS BALANCE DUE. I WILL BE HELD RESPONSIBLE FOR FEES ASSOCIATED WITH THE COLLECTION OF THIS DEBT.

SIGNATURE: _____ DATE: _____