

DATE _____

BLUE RIDGE BONE & JOINT CLINIC, P.A.

HISTORY _____

CODE _____

PATIENT INSURANCE INFORMATION WORKSHEET

DOCTOR _____

PLEASE COMPLETE ALL OF THE REQUESTED INFORMATION

Patient Name: _____
Last First Middle Home Phone

Mailing Address: _____
Street Name or PO Box City State Zip Code

Male Female / /
Sex Birthdate Age Social Security Number

Parent / Legal Guardian Social Security Number

Patient or Parent's Employer Occupation

Employer Address Work Phone #

Marital Status Spouse's Name Spouse's Employer Phone Number

Name of Insurance	Address	Policy Holder	SSN / Cert#	Date of Birth	Group #	Is the following Required?
FIRST:				____/____/____ Month Day Yr		<input type="checkbox"/> PRE-CERTIFICATION <input type="checkbox"/> SECOND OPINION
SECOND:				____/____/____ Month Day Yr		<input type="checkbox"/> PRE-CERTIFICATION <input type="checkbox"/> SECOND OPINION
THIRD:				____/____/____ Month Day Yr		<input type="checkbox"/> PRE-CERTIFICATION <input type="checkbox"/> SECOND OPINION

Were you referred by another physician? _____
Physician's Name (first & last) Address

Have you been treated by any of our Physicians before? (in the Office or in the Hospital) Yes No

If yes, which Doctor? _____ When? (date) _____

Name of Contact in Case of Emergency _____ Phone Number _____

yes no
Were you injured at work? Name of Contact to Verify Your Claim? Phone Number

Address for Mailing Your Claim? _____

We request payment at the time of service for office charges.

I consent to treatment at Blue Ridge Bone & Joint and Blue Ridge Physical Therapy Center, and release of information for insurance purposes and assignment of benefits on insurance filed on unpaid services.

Patient's Signature: _____
(Or Patient's Representative Signature)