

- Schneider Smith
 Nicola Hansen



Account # _____

Date _____

Reason For Treatment _____ Date of Injury, or 1st symptom ____/____/____
 Left Other
 Right

Patient's Legal Name: Last _____ First _____ Middle _____ Male
 Female
 Home Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell/Pager _____ Age _____ D.O.B. _____ Marital Status
 M S D W
 S.S.# _____ Work Phone _____ Ext. _____
 Patient's Employer _____ Occupation _____
 Spouse's Name _____ D.O.B. _____ Employer _____
 Spouse's S.S.# _____ Work Phone _____ Occupation _____
 Can we contact you by email: Yes No Email: _____

Patient's legal guardian _____
 Father's Name (IF MINOR) _____ S.S.# _____ D.O.B. _____
 City, State, Zip _____ Phone _____
 Father's Home Address _____
 Father's Employer _____ Occupation _____ Work Phone _____
 Mother's Name (IF MINOR) _____ S.S.# _____ D.O.B. _____
 City, State, Zip _____ Phone _____
 Mother's Home Address _____
 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 E/R Physician: (Please 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 _____
 Subscriber Name _____ Relationship to Subscriber
 Self Spouse Child Step Parent Other Copay\$ _____
 Subscriber D.O.B. _____ I.D. No. _____ Group No. _____
SECONDARY INSURANCE COMPANY NAME _____ Phone _____
 Insurance Co. Address _____
 Subscriber Name _____ Relationship to Subscriber
 Self Spouse Child Step Parent Other
 Subscriber D.O.B. _____ I.D. No. _____ Group No. _____

Motor Vehicle Accident <input type="checkbox"/> yes <input type="checkbox"/> no	Attorney Involved <input type="checkbox"/> yes <input type="checkbox"/> no	State _____	Attorney Name, Address & Phone _____
Work-Related Injury <input type="checkbox"/> yes <input type="checkbox"/> no	Date of Injury, or 1st symptom ____/____/____	Have you notified your employer of your injury <input type="checkbox"/> yes <input type="checkbox"/> 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 by 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 as 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.

Patient/Legal Guardian Signature _____ Date _____