



RONALD W. SMITH, M.D.

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PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY)

PATIENT

PATIENT NUMBER		DOCTOR			TODAY'S DATE	
PATIENT'S LEGAL NAME			DATE OF BIRTH	AGE	SOCIAL SECURITY #	CELL NO.
NAME PREFERENCE			DRIVER'S LICENSE #		SEX	MARITAL STATUS
STREET ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY			CITY AND STATE		ZIP CODE	AREA CODE
PATIENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)		AREA CODE	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS			CITY AND STATE			ZIP CODE
IN CASE OF EMERGENCY CONTACT:				PHONE #	RELATIONSHIP	
SPOUSE'S NAME		DATE OF BIRTH	SOCIAL SECURITY NO.		DRIVER'S LICENSE #	
SPOUSE'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)			BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP CODE	
WHO REFERRED YOU TO THIS OFFICE?						
HAVE WE EVER TREATED ANY MEMBERS OF YOUR FAMILY? (Y/N)				NAME OF YOUR FAMILY DOCTOR:		

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME		STREET ADDRESS / CITY / STATE / ZIP			HOME PHONE #
MOTHER'S EMPLOYER		BUSINESS PHONE NO.		SOCIAL SECURITY NO.	
EMPLOYER'S STREET ADDRESS		CITY / STATE /			ZIP
FATHER'S NAME		STREET ADDRESS / CITY / STATE / ZIP			HOME PHONE #
FATHER'S EMPLOYER		BUSINESS PHONE #		SOCIAL SECURITY NO.	
EMPLOYER'S STREET ADDRESS		CITY / STATE / ZIP			

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE		STREET ADDRESS		CITY / STATE / ZIP		HOME PHONE #
INSURANCE NAME & ADDRESS		NAME OF POLICY HOLDER		CERTIFICATE #		GROUP #
INSURANCE NAME & ADDRESS		NAME OF POLICY HOLDER		CERTIFICATE #		GROUP #
MEDICARE		MEDICARE #				
MEDICAID		PROGRAM #			COUNTY #	

INJURY

DESCRIBE INJURY AND HOW IT HAPPENED		
<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER (Explain)		
		DATE OF INJURY
		APPROXIMATE TIME OF INJURY

PROVIDER'S FINANCIAL POLICY

Please note that payment in full is required at the time of service. For your convenience, we accept personal checks, Visa, Master Charge or American Express, as well as cash. Any insurance coverage that you may have is intended to protect you against financial loss and not as payment in full for your care. Payment in full for your care is your responsibility and may not be postponed until the time your insurance reimburses you. This agreement will remain in effect until revoked by (the patient) (or provider?) in writing. A photocopy of this document is to be considered as valid as the original.

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the listed medical insurance, either electronically or manually, by the listed facility. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to be paid to the listed provider assignee. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

PATIENT'S TREATMENT AUTHORIZATION

I authorize treatment by the Balance Orthopaedic Foot and Ankle Center. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all the charges incurred, regardless of insurance coverage or liability of another party. I will make sure that my claims are paid promptly.

Patient's Name (Please Print) Signature of Patient/Guardian Date

TREATMENT OF MINOR

I authorize Balance Orthopaedic Foot and Ankle Center to treat the minor named below.

Minor's Name Signature of Parent/Guardian Date