



Welcome to Charleston Orthopaedic Associates!

Were you referred by another physician? Y N (circle one) If yes, who? _____

Patient information

Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Work/Cell Phone:** _____

Email Address: _____ **Social Security Number:** _____

Marital Status (Circle one) S M D W **Birth Date:** _____ **Race:** _____ **Sex:** _____

Employer Information

Employer Name: _____

Employer Address: _____ **City/State/Zip:** _____

Is your visit today due to an injury or accident? Yes or No **Date of Injury:** _____

Was your accident or injury a result of: Car Accident Work Related (circle one) **OR**
Other Accident? _____

Insurance Information

***Insurance Company name:** _____

Insured name: _____ **Relation to the patient?** Self Child Spouse

Insured SSN: _____ **Policy number:** _____

Group name/number: _____ **Effective date:** _____

***Secondary Insurance Company name:** _____

Policy number: _____ **Relation to the patient?** Self Child Spouse

Group name/number: _____ **Effective date:** _____

Liability Carrier Information

Do you have an Attorney? Yes or No **If yes, Attorney's name:** _____

Attorney Phone number: _____ Fax number: _____

Attorney Address: _____ City/State/Zip: _____

If your injury is **Work Related**, Work Comp Insurance Carrier name: _____

Work Comp Address: _____ City/State/Zip: _____

Work Comp Claim number: _____ Work Comp Phone number: _____

Adjuster name: _____ Phone number: _____

Nurse Case Manager name: _____ Phone number: _____

Emergency Contact Person: _____ **Relation:** _____

Phone number: _____ **Work/Cell:** _____

I attest that the information listed above by me is a true, accurate and correct statement. I give consent for treatment from Charleston Orthopaedic Associates. I hereby authorize release of any medical information necessary to process my insurance claim and I also assign to the Doctor all payments from Medicare, Blue Cross/Blue Shield or other Insurance for services rendered. I am responsible for any remaining balance after all insurance payments have been received, when insurance is applicable, or any remaining account balance when insurance is not involved. I also agree that I will be responsible for any costs regarding returned check fees, court costs and/or attorney's fees, should they be incurred.

If you are a patient that is being seen as Legal patient (your bill is being protected by an attorney), **you are responsible for services rendered regardless of settlement.** If there is no settlement or partial settlement, you are still responsible for the entire balance. Also, as a legal patient, if you have private insurance, it will **not** be filed for any Charleston Orthopaedic Associates services. Private insurance information **will be requested and is required** in the event of a diagnostic test or surgery at another facility that does not accept Legal patients.

I understand and agree to the above conditions.

Patient Signature

Today's Date