



ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

PATIENT INFORMATION SHEET (Please Complete In Full)

Patient's Information:

Patient Name: _____ Age _____ Sex _____ Date of Birth _____
Last First MI

Address: _____ City _____ State _____ Zip _____

Home Phone # - (_____) _____ Alternative # - (_____) _____ Marital Status: S M D W

Social Security # _____ Drivers License # _____ State _____

Employer _____ Job Description _____ Work #- (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Referred By _____ Family Physician _____

Spouse or Parent Name (circle one) _____ DOB _____ S.S.# _____

Spouse or Parent Employer _____ Work #- (_____) _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Phone # - (_____) _____

Policyholder Name _____ I.D. _____ Group _____

Policyholder Date of Birth _____ S. S. # _____

Insurance Address: _____
Street City State Zip

Secondary Insurance Co: _____ Phone # - (_____) _____

Policyholder Name _____ I.D. _____ Group _____

Policyholder Date of Birth _____ S. S. # _____

Insurance Address: _____
Street City State Zip

Reason for seeing Doctor / symptoms- _____ Date of Injury _____

Was injury sustained on the Job? Yes _____ No _____ If yes, was this filed with employer as Worker
Compensation? Yes ---- No _____ If yes, what is the claim #? _____

Adjustor's Name: _____ Phone # - (_____) _____

Emergency Contact Relation: _____ Phone # - (_____) _____

Contact (not living in same household) Name: _____ Phone # - (_____) _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, and other government sponsored programs, private insurance, and any other plan to: ARLINGTON ORTHOPEDIC ASSOCIATES, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Person Responsible For Bill Please Sign Legal Full Name-

Your e-mail address will be used as your legal signature if submitted electronically. _____ Date _____