# ORTHOPEDIC SPECIALISTS, S.C
# 360 W BUTTERFIELD RD
# SUITE 160
# ELMHURST, IL 60126

| Patient Information | | | | |
|---|---|---|---|---|
| Last Name: | First Name: | | | M.I: |
| Mailing Address: (No P.O. Box) | | | Apt# | |
| City/State/Zip: | | | | |
| Home Phone: | Cell Phone: | Email: | | |
| Family or Referring Physician: | | Date of Birth: | Sex: | Height:<br>Weight: |
| Marital Status: | Social Security #: | | | |
| Employer Name: | Emergency Contact Name: | | | |
| Emergency Contact Phone #: | Relationship to Patient: | | | |

| **Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor** | | |
|---|---|---|
| Last Name: | First Name: | |
| Date of Birth: | Social Security #: | Phone: |
| Address of Person Responsible: | | |
| City/State/Zip: | Relationship to Patient: | |

| Primary Medical Insurance | Secondary Medical Insurance |
|---|---|
| Ins. Co. Name: | Ins. Co. Name: |
| Policy Holder Name: | Policy Holder Name: |
| Policy Holder's Date of Birth: | Policy Holder's Date of Birth: |
| Policy Holder's Social Security #: | Policy Holder's Social Security #: |
| Patient Relationship to Policy Holder: | Patient Relationship to Policy Holder: |
| Patient Policy #: | Patient Policy #: |

AUTHORIZATION: I hereby authorize Orthopedic Specialists, S.C. to release any information contained in my medical record to my insurance company, referring physician, and/or primary care doctor. I also authorize for benefits to be paid directly to Orthopedic Specialists, S.C. for medical services I received from any of the healthcare providers in this practice. I understand that I will be responsible for any unpaid balances, including charges for which a referral was not obtained. If this account goes to collections, I will be liable for collection costs and attorney fees.

SIGNATURE:_____DATE:_____