MILLSAP VALLEY ORTHOPAEDICS & SPORTS MEDICINE

Personal and Insurance Information

Date of Injury_________ **Primary Care Physician**___________________________ **Work Comp Physician** _________________

Patient Information

Name ____ Soc. Sec. # ___________________________
Last Name First Name Initial

Cell Phone _________________ Home Phone ____________________ Email Address_________________________

Address ____

City ____ State _______________ Zip ___________________________

Sex ☐ M ☐ F Age ________ Birthdate _________________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed By ____ Occupation __________________________

Business Address____ Work Phone _________________________

Whom may we thank for referring you? ____

In case of emergency who should be notified____ Phone ______________________

Primary Insurance

Policy Holder for Account ____
Last Name First Name Initial

Relation to Patient____________________________ ***Birthdate***_________________ ***Soc. Sec. #*** _________________

Address (if different from patient's)____ Phone ______________________

City ____ State _______________ Zip ___________________________

Person Responsible Employed by _____________________________________ Occupation __________________________

Business Address____ Business Phone _______________________

Insurance Company ____

Identification # _______________________ Group # _________________________

Name of other dependents covered under this plan____

Additional Insurance

Is there or could there be a liability claim for this injury? ☐Yes ☐No

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name ________________________________ Relation to Patient _______________ Birthdate _______________

Address (if different from patient's)____ Phone ______________________

City ____ State _______________ Zip ___________________________

Subscriber Employed by____ Business Phone ____________________

Insurance Company ____

Identification # _______________________ Group # _________________________

Name of other dependents covered under this plan____

Assignment and Release

I, the undersigned, certify that I (or my dependent) with any or all insurance coverage do assign directly to Donal B Rose, M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Additionally I agree to pay a 1.5% monthly interest on all unpaid balances exceeding 90 days. I understand the minimum payment due on all unpaid balances is $50 per month. Failure to pay a minimum payment may result in collection procedures. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ____________________________________ _______________
Responsible Party Signature Relationship Date