DANVILLE ORTHOPAEDICS & SPORTS MEDICINE, P.S.C.
333 S. Third Street, Suite B
Danville KY 40422

PATIENT INFORMATION

Title: Mr.__ Mrs.__ Ms.__ Miss__
Last name: ___________________________
First name: ___________________________
Middle Initial: ____
Address: ______________________________
City: _________________________________
State: ______ Zip Code: ___________
Responsible party (if other than patient):
____
____
____
Power of attorney/legal representative: Yes__ No__

Social Security Number:______________________________
Phone: ___________________Cell:_______________________
Pager: ___________________Fax:_______________________
Sex: M __ F __
Marital Status: M __ S __ D __ W __ Sep __
Date of Birth: ____________________
Name and address of Next-of-Kin:
Relationship to patient:
Emergency phone#/name:______________________________

Who referred you to Danville Orthopaedics & Sports Medicine?
Self ___ Family ___ Friend ___ Physician ___ Other (please specify): ____________________________

Referring Physician: ________________________ Family Physician: ________________________

Have you been a patient here before? Yes ___ No ___ (If yes, when and under what name: ______________________________)

EMPLOYMENT

Employer: ____ Employer Phone: _____________________________

Address: ____________________________ City: ________________ State: ____ Zipcode: ________________

MEDICAL INFORMATION

Reason for being seen: ____
Is this an injury? Yes ___ No ___
If yes: Date of injury: ______________
Type of injury: Worker's Comp ___ Auto Accident ___ Other (describe): ________________________________
State in which injury occurred: ______
Known drug allergies:____

INSURANCE INFORMATION

	First Insurance:	Second Insurance:	Third Insurance:
Insurance company	________________	________________	
ID number	________________	________________	________________
Group number	________________	________________	
Claim number	________________	________________	
Insurance address	________________	________________	________________
Policyholder's name	________________	________________	
Patient's relationship to policyholder:	________________	________________	
Policyholder date of birth:	________________	________________	
Policyholder soc sec #:	________________	________________	

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I hereby authorize Danville Orthopaedics & Sports Medicine to release any medical information necessary for treatment coordination and/or billing purposes . I further authorize and permit payment by my insurance company directly to Danville Orthopaedics & Sports Medicine for services provided by them. I recognize and accept financial responsibility for payment of services regardless of insurance coverage. This includes, but is not limited to, co-insurance, co-payments, deductibles, and non-covered services.

SIGNATURE:____ DATE: ________________