CALIFORNIA ORTHOPEDICS & SPINE

Patient Demographic

Patient Information

Name:_____ Date Today:_____ Date of Injury:_____

Address:_____ Date of Birth:_____ Age:_____

City:_____ State:_____ Zip:_____ Home Phone #_____

Email:_____ Cell Phone #_____

Social Security:_____ Pharmacy & City Location:_____

❑ Male ❑ Female Marital Status:_____ Occupation:_____

Employer:_____ City:_____ Zip:_____

Employer Address:_____ Work Phone #_____

Spouse/Parent Name:_____

In Case of Emergency Notify:_____ Emergency Contact Phone #_____

Primary Care Physician (PCP):_____ Injured Body Part:_____

Sports/Hobbies/Activities:_____

Special Needs:_____

IT IS A FEDERAL REQUIREMENT THAT CALIFORNIA ORTHOPEDICS & SPINE REPORTS THE FOLLOWING:

*Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to State

*Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Black or African American ❑ White ❑ Decline to State

*Preferred Language: _____

* This information will be held confidential and only a limited number of people will have access to the data

Insurance Information

How are you planning on paying for your visit today with the doctor (check ***ONE*** only)

Medical Insurance: _____ Workman Compensation Insurance/Claim: _____

Privately Paying/Cash: _____ Motor Vehicle Insurance/Claim: _____

Subscriber or Policy Holder:_____ Subscriber Birth date:_____

Name as it appears on insurance card:_____

Relationship to subscriber/insured:_____ Subscriber Social Security #_____

Insurance Carrier:_____ Phone #_____

Claim Address:_____ City:_____ State:_____ Zip:_____

Insurance I.D.#_____ Group/Plan #_____

Secondary Insurance:_____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to my physician (California Orthopedics & Spine). I understand I am financially responsible for non-covered services and also authorize my physician to release any information required.

_____ _____

Patient Signature Date