NORTHEAST ORTHOPEDICS & SPORTS CLINIC

PATIENT INFORMATION QUESTIONNAIRE

DATE: _____

NAME: _____
LAST FIRST MIDDLE INITIAL NICKNAME

MARITAL STATUS: _____ SEX: ☐M ☐F AGE: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE HOME: ( ) _____ WORK ( ) _____ CELL ( ) _____

SOC. SEC. # _____ EMERGENCY NAME: _____ PHONE: ( ) _____

NAME OF SPOUSE/PARENT _____ EMPL: _____ PHONE: ( ) _____

SOC. SEC. # OF SPOUSE/PARENT: _____

COMPLAINT: _____ Right ( ) Left ( ) SYMPTOM/ACCIDENT DATE: _____

HOW DID ACCIDENT HAPPEN? _____

_____ LOCATION: _____

PATIENT'S EMPLOYER/SCHOOL: _____ WERE X-RAYS TAKEN: YES ☐ NO ☐

REFERRING COACH/ATHLETIC TRAINER: _____ REFERRING PHYSICIAN: _____

REFERRING FAMILY MEMBER/FRIEND: _____ FAMILY PHYSICIAN: _____

HOSPITAL PREFERENCE: _____

PRIMARY INSURANCE CO: _____

POLICY HOLDER: _____

Relation to Patient: _____

Date of Birth: _____

Insured Social Security #: _____

CO-PAY: _____

POLICY # _____

GROUP # _____

INSURANCE CARD HOLDER'S EMPLOYER:

Name: _____

SECONDARY INSURANCE CO: _____

POLICY HOLDER: _____

Relation to Patient: _____

Date of Birth: _____

Insured Social Security #: _____

CO-PAY: _____

POLICY # _____

GROUP # _____

INSURANCE CARD HOLDER'S EMPLOYER:

Name: _____

IS THIS A WORKMEN'S COMPENSATION CASE? NO YES

Date of Accident: _____

Employer: _____

Mailing Address: _____

City/State/Zip: _____

Appt. Date/Time: _____

Physician: _____

Approved by: _____

If YES, fill in the following:

Date last worked: _____

W/C Carrier: _____

Address: _____

_____

ATTN: _____

Phone: _____

Claim #: _____

I ACKNOWLEDGE THAT A COPY OF THE PRIVACY POLICIES OF NORTHEAST ORTHOPEDIC CLINIC, P.C. HAS BEEN MADE AVAILABLE TO ME. _____ (initial)
I hereby authorize Northeast Orthopedics and Sports Clinic (NEO) to furnish information to insurance carriers and any other medical providers rendering services to me under the direction of NEO concerning my illness and treatments rendered by NEO or such other medical providers, and hereby assign to NEO all payments for medical and/or surgical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance. I agree to pay all costs of collection, including a reasonable attorney's fee, should this account be placed with an attorney for collection. I waive all rights of exemption under the Constitution and the Laws of the State of Alabama.

Date: _____ Signature: _____

Relationship to Patient: _____ DOB: _____ SS#: _____

70800 (256) 442-2333