DANBURY ORTHOPEDICS
Exceptional Care. Real Results.

PATIENT INFORMATION FORM

DATE: _____

Patient's Name (First, Middle, Last)	Date of Birth	Social Security No.
Patient's Address	Apt. No.	
City	State	Zip
Home Phone with Area Code	Cell Phone No.	Sex: ❑M ❑F
Primary Care Physician's Name	Phone with Area Code	
Referring Doctor	Address	City, State, Zip

FILL IN IF PATIENT IS A MINOR

Parent's Name (First, Middle, Last)	Date of Birth	Social Security No.

ACCIDENT INFORMATION - ❑ Work Injury ❑ Automobile Injury ❑ School/Sports Related ❑ Liability ❑ Other

Date of Accident and Description		
Employer at Time of Accident	Employer's Address	Phone with Area Code

INSURANCE - PRIMARY

Policy Holder's Name (If other than Patient)	Date of Birth	Social Security No.
Policy #	Group#	Phone with Area Code
Employer Name	Address	Phone with Area Code

INSURANCE - SECONDARY

Policy Holder's Name (If other than Patient)	Date of Birth	Social Security No.
Policy #	Group#	Phone with Area Code
Employer Name	Address	Phone with Area Code

ASSIGNMENT OF MEDICAL BENEFITS/GUARANTEE OF FINANCIAL RESPONSIBILITY

I request that payment of authorized medical benefits be made directly to Danbury Orthopedic Associates, PC. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am Financially Responsible for all charges whether or not paid by said insurance. In the event that I fail to pay charges due and Danbury Orthopedic Associates, PC refers my account to collection, I agree to pay cost of collections, including a reasonable attorneys' fee. For Medicare patients, this applies to the Social Security Administration, Centers for Medicare and Medicaid Services or its intermediaries or carriers.

Patient or Legal Guardian Signature _____ Date _____