



Chart #: _____

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST.

How were you referred to our office? _____

PATIENT INFORMATION:

First Name: _____ Last Name: _____ M.I. _____ Maiden Name: _____

Residential Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____ Social Security #: _____

Date of Birth: ____/____/____ Age: _____ Race: _____ Sex: [] Male [] Female Student: [] Yes [] No

Marital Status: [] Single [] Married [] Divorced [] Widowed [] Legally Separated

Employer: _____ Employer Phone: _____

Spouse's Name: _____ Spouse's SS#: _____

Spouse's Employer: _____ Spouse's Employer Phone: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE CONSENT AND PARENT INFORMATION:

I, being the parent/guardian do hereby request and authorize Carolina Orthopaedic Specialists, P.A. or persons designated by them to perform necessary services for my child, including, but not limited to, x-rays, and administration of anesthetics which are deemed advisable by the physician, whether or not I am present at the actual appointment when the treatment is rendered.

DATE: _____ SIGNATURE OF PARENT/GUARDIAN: _____

Father's Name _____ Father's SS#: _____ Date of Birth _____

Employer: _____ Employer Phone: _____

Mother's Name: _____ Mother's SS#: _____ Date of Birth _____

Employer: _____ Employer Phone: _____

IN CASE OF EMERGENCY, PLEASE GIVE THE NAME AND TELEPHONE NUMBER OF THE NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:

(Name) (Relationship) (Phone)

INSURANCE INFORMATION

1. PRIMARY INSURANCE _____ EMPLOYER _____

Insured's Name: _____ Insured SS#: _____

Policy #: _____ Group #: _____

Relationship to patient: _____ Insured's Date of Birth: _____

2. SECONDARY INSURANCE _____ EMPLOYER _____

Insured's Name: _____ Insured SS#: _____

Policy #: _____ Group #: _____

Relationship to patient: _____ Insured's Date of Birth: _____

Signature: _____ Relationship to patient: _____ Date: _____