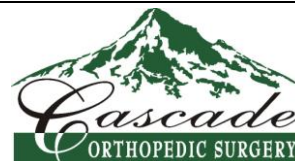


◆ PATIENT INFORMATION FORM ◆



Ronald L. Teed, M.D., PC

Last Name: _____ First Name: _____ MI: _____

Male Female Date of Birth: _____ Age: _____ Social Security Number: _____

Home Address: _____ Driver's License # / Picture ID: _____

City _____ State: _____ Zip Code: _____

*** If mailing address is the same as home address, check here:

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone #: _____

Primary Care Doctor (PCP): _____ PCP Phone #: _____

Email Address: _____ Referred to our clinic by: _____

Patients preferred spoken language: _____ Race / Ethnicity (please): _____

Patient's Marital Status: Single Married Divorced Widowed Other

Parent Spouse Guardian Information: *Parent accompanying minor child, please complete below information*

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security Number: _____ Spoken Language: _____

Employer: _____ Work Phone #: _____ Driver's License #: _____

Marital Status: Single Married Divorced Widowed Other

Emergency Contact Information:

Name: _____ Phone #: _____ Relationship: _____

◆ INSURANCE INFORMATION: ◆

◆ Are you being seen for a ****WORK INJURY**** or a ****MOTOR VEHICLE ACCIDENT****? Yes No

Primary Insurance Carrier: _____ ID Number: _____

Policyholder: Patient Spouse Parent Guardian Group Number: _____ Copay: _____

Policyholder Name: _____ Date of Birth: _____ SSN: _____

Policyholder contact phone #: _____ Home Cell Work Driver's License # _____

Secondary Insurance Carrier: _____ ID Number: _____

Policyholder: Patient Spouse Parent Guardian Group Number: _____ Copay: _____

Policyholder Name: _____ Date of Birth: _____ SSN: _____

Policyholder contact phone #: _____ Home Cell Work Driver's License # _____

◆ ◆ DOES YOUR INSURANCE PLAN REQUIRE A REFERRAL FOR SPECIALIST CARE? ◆ ◆

➔ Please make sure the referral has been completed prior to your appointment ←

I hereby:

- Authorize Cascade Orthopedic Surgery to release information to my insurance carrier(s) concerning my illness, injury or treatment.
- Acknowledge that I am ultimately responsible for any prior authorization(s) or referral(s) required by my insurance.
- Assume complete financial responsibility for any and all costs denied, rejected or pended by my insurance for extended periods of time.

Signature: _____ Date: _____