◆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:** _____