

Office Use Only
Initials
Date
Doctor

**Patient Information Form**  
**Personal Information**

Patient:			Last Name			First Name			Middle			
Mr.	Mrs.	Ms.										
Patient's Address				Apt # (PO Box #)		City			State		Zip Code	
Social Security #			Date of Birth		Age	Home Phone #			Sex		Marital Status	
Patient Employed By			Employer's Address			City		State	Zip Code		Phone #	
Spouse's Name				Social Security #		Spouse's Employer / Employer's Address				Phone #		
Referred By / Physician			Physician's Address			Emergency Contact			Relationship		Phone #	

**Guarantor Information**

Complete This Section If Someone Other Than The Patient Is Responsible For The Medical Bill

Guarantor's Name			Address			City		State		Zip Code	
Relationship To Patient		Home Phone #		Business Phone #		Social Security #		Date of Birth		Occupation	
Employed By			Employer's Address			City		State		Zip Code	

**Insurance Information**

We Bill Your Insurance As A Courtesy

<b>Who Is Responsible For Payment Of This Claim? (Check Appropriate Box)</b>													
Self	<input type="checkbox"/>	Health Insurance	<input type="checkbox"/>	Worker's Comp	<input type="checkbox"/>	Liability Claim	<input type="checkbox"/>	Auto Insurance	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
Medicare #			Medicaid #										
Insurance Company 1		Address			City		State	Zip Code		Phone #			
Group Name		Group #	Policy #		Policy Holder's Name		Policy Holder's SS #		Occupation				
Insurance Company 2		Address			City		State	Zip Code		Phone #			
Group Name		Group #	Policy #		Policy Holder's Name		Policy Holder's SS #		Occupation				
Worker's Comp / Company			Manager Authorizing Treatment			Phone #		Claim Number					
Address			Apt # (PO Box #)		City		State		Zip Code				

**Assignment Of Benefits**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BONUTTI ORTHOPAEDIC SERVICES, LTD. I UNDERSTAND I AM PERSONALLY RESPONSIBLE FOR ALL FEES OF BONUTTI ORTHOPAEDIC SERVICES, LTD. ALSO I UNDERSTAND I WILL BE ASSIGNED A FINANCE CHARGE OF 1.5% PER MONTH FOR ALL FEES OVER 90 DAYS PAST DUE.

Patient's Signature		Date		Guarantor's Signature		Date	
X				X			

**Payment Is Due At Time Of Service**