RENEW. RESTORE. RECLAIM.

Patient Name ______________________________________ Sex **M** **F**
First MI Last

Date of Birth ___/___/___ Age_____ Social Security # ____________________

Marital Status M W D S Driver License # ____________________

Cell Phone ____________________ Home Phone ( ) ____________________

Email ____________________ Emergency Name ____________________

Address____________________ Emergency Phone ____________________

City ____________________ State __________ Zip __________

Employer ____________________ Work Phone ( ) ____________________

Occupation ____________________ Currently working **Yes / No**

Referring Doctor ______________________________________
First Name Last Name Address

REQUIRED TO BILL INSURANCE

Primary Insurance ____________________ ID: ____________________

Subscriber's Name____________________ Subscriber's D.O.B____________________

Group or Local____________________ Date of Injury ____________________

Secondary Insurance ____________________ ID: ____________________

Subscriber's Name____________________ Subscriber D.O.B ____________________

Group or Local____________________ Date of Injury ____________________

Your signature authorizes Sah Orthopaedic Associates to furnish the above-mentioned insurance company(ies) all information they may request. I hereby assign to Sah Orthopaedic Associates all basic and major medical expense relative to the services rendered. It is understood that any money received from the above named insurance companies, over and above my indebtedness, will be refunded to me when my bill is paid in full. Payment in full is requested of any unpaid balance over 45 days. I also understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Sah Orthopaedic Associates can only bill my insurance provided I supply accurate and current information. I agree to respond in a timely manner to any request from my insurance for any illness/accident/injury information they may request directly from me. Failure to do will make me liable for the debt to Sah Orthopaedic Associates. All supplies that I may receive will also be my financial responsibility and payable when received. Medicare patients are responsible for supplies after Medicare is billed.

Patient Signature______________________________ **Date**____________________