

# Welcome To Our Office

**Legal Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Birth date:** \_\_\_\_\_ **Patient's SS#:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **St:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** ( ) \_\_\_\_\_ **Cell:** ( ) \_\_\_\_\_

**Employers or School:** \_\_\_\_\_

**Work/School Phone:** ( ) \_\_\_\_\_ **May we call you at work?** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Marital Status:** Married Single Divorced Widowed **Birth date:** \_\_\_\_\_

**Name of Spouse:** \_\_\_\_\_ **Spouse's SS#:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Employer's Phone ( ):** \_\_\_\_\_

**Nearest emergency contact outside of your home:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Home Phone:** ( ) \_\_\_\_\_ **Work Phone:** ( ) \_\_\_\_\_ **Cell:** ( ) \_\_\_\_\_

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**Complete this section only if under the age of 18**

**Father's Full Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **St:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** ( ) \_\_\_\_\_ **Work Phone:** ( ) \_\_\_\_\_

**Mother's Full Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **St:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** ( ) \_\_\_\_\_ **Work Phone:** ( ) \_\_\_\_\_

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I understand and agree that if I have no insurance coverage, or if my claim is a result of a third party injury, payment is due at the time of service.

I understand and agree that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Arnold Orthopaedic and Sports Medicine.

I authorize Arnold Orthopaedic and Sports Medicine to release pertinent medical information to my insurance company when requested, to facilitate payment of a claim.

I understand and agree that it is my responsibility to inform the staff of Arnold Orthopaedic and Sports Medicine as to which hospital or outside facility is in my insurance network.

**Signature of Patient or Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_