WESTERN SLOPE
ORTHOPAEDICS

PHYSICIAN TO BE SEEN: _____ **Date:** _____

NAME: Last _____ **First:** _____ **MI:** _____

Mailing Address: _____ **City/State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Social Security Number: _____-_____-_____ **Date of Birth:** _____ **Age** _____

Employer: _____

Family Physician: _____ **Referred to us by:** _____

E-MAIL ADDRESS: _____

Appointment Reminders: Text Message ☐ Phone Call ☐ E-mail ☐

IF PATIENT IS A MINOR - GUARANTOR INFORMATION

Guarantor's Full Name: _____

Guarantor's Address: _____

Guarantor's SSN: _____-_____-_____ **Guarantor's Date of Birth:** _____

INSURANCE INFORMATION

Insured's Name: _____ **Insured's Date of Birth:** _____

Patient's Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

If Workmen's Comp or Auto Claim, please provide the following: Claim# _____

Name and Address of Insurance Carrier: _____

Adjuster's Name _____ **Phone #** _____ **ext.** _____

INJURY INFORMATION

Date of Injury: _____

Is This A Work Comp Injury? ☐ Yes ☐ No **Auto Accident?** ☐ Yes ☐ No **Other Injury?** ☐ Yes ☐ No

How Did Your Injury Occur? _____ **Where?** _____

Which Body Part is Injured? _____ **Right** _____ **Left** _____

If Non-Injury, What Body Part? _____

Turn Page Over ⟶

CONTINUED ON NEXT PAGE

WESTERN SLOPE
ORTHOPAEDICS

Western Slope Orthopaedics has my permission to release my personal medical information to the following people:

Name:_____Relationship:_____Phone # _____

Name:_____Relationship:_____Phone # _____

Name:_____Relationship:_____Phone # _____

I DO NOT want my personal medical information released to the following individuals or organizations:

Name or Business: _____

Name or Business: _____

Name or Business: _____

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INSURANCE ACKNOWLEDGEMENT/AUTHORIZATION

You are responsible for supplying your own personal insurance, or work comp/auto information to our office. If you do not give us your information, **you** will be responsible for all charges incurred and payment will be expected at the time of service.

I request that payment of authorized insurance benefits be made on my behalf to Western Slope Orthopaedics for any services rendered to me by Ryan K. Albrecht, M.D., Joshua J. Bagley, M.D., C. Kelly Bynum, M.D., Thomas F. Dwyer, M.D., Timothy R. Judkins, M.D. and Vineet Singh, M.D. I authorize any holder of medical information needed to determine these benefits payable for related services rendered. I understand that I am responsible for any amount of my charges **NOT** covered by my insurance. All information on this form is true to the best of my knowledge. I agree to the information stated above. A photocopy of this authorization shall be considered as valid as the original.

_____ _____

Signature of Patient/Guarantor **Print Name of Patient/Guarantor**

_____

Date