



## RESPONSIBLE PARTY (BILL TO) INFORMATION

➔ If PATIENT is 18 years old or older and is the responsible party, skip this section and go to the EMERGENCY CONTACT section.

➔ If someone other than the patient is the responsible party, complete the following information:

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_  M  F

Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

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

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Employer Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

1.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

2.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

## REFERRAL INFORMATION

Who referred you?  Family or Friends  Doctor \_\_\_\_\_  If other, specify: \_\_\_\_\_

Who is your family physician? \_\_\_\_\_

## INSURANCE INFORMATION

➔ If you have an HMO insurance plan, did you contact your Primary Care Physician (PCP) for a referral?  Yes  No

1.) Primary Insurance Company: \_\_\_\_\_

Group or Account #: \_\_\_\_\_ ID or Policy #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

2.) Secondary Insurance Company: \_\_\_\_\_

Group or Account #: \_\_\_\_\_ ID or Policy #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts on the date of service. By signing this form, I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I authorize the release of any medical information necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to Premier Orthopaedics & Sports Medicine, PLC.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Today's Date