



Patient Information:	
Name: _____	Date of Birth: ____/____/____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address: _____	Age: ____ Social Security #: _____ - _____ - _____
_____	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W
City, State, Zip: _____	How did you hear about us: _____
Primary Phone: (____)____ - _____	(Examples: doctor, another patient, emergency room, internet, OSC staff, yellow pages, established patient, etc.)
Alternate Phone: (____)____ - _____	Family Physician: _____
Alternate Phone: (____)____ - _____	Family Physician Phone: (____)____ - _____
Email Address: _____	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Other: _____	
Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian or Pac. Islander <input type="checkbox"/> Decline	
Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline	

Patient Employment Information:	Emergency Contact Information:
<input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other	Name: _____
Employer's Name: _____	Phone: (____)____ - _____
Employer's Phone: (____)____ - _____	Relationship: _____
Occupation: _____	

Responsible Party: (Only fill out if patient is under 18 years of age.)	
Name: _____	Relationship: _____
Address: _____	Home Phone: (____)____ - _____
City, State, Zip: _____	Work Phone: (____)____ - _____
Employer: _____	SSN: ____ - ____ - _____ Date of Birth: ____/____/____

Primary Insurance:	Secondary Insurance:
Insurance Company: _____	Insurance Company: _____
ID #: _____	ID #: _____
Group/Policy #: _____	Group/Policy #: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber SSN: ____ - ____ - _____	Subscriber SSN: ____ - ____ - _____

Work or Motor Vehicle Related Injury: (Only applicable if injury is related to work or auto accident)	
Claim Number: _____	Date of Injury: ____/____/____
Insurance Carrier Name: _____	Claim Manager Name: _____
Address: _____	Claim Manager Phone: (____)____ - _____
City, State, Zip: _____	Employer at time of injury: _____

Insurance Authorization and Assignment: (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I authorize Orthopaedic Specialty Clinic of Spokane (OSC) to bill and collect payment(s) from my insurance carrier(s) and to release information necessary for the purpose of collecting such payment(s). I authorize my insurance company to pay directly to OSC for their services. I understand it is my responsibility to contact my insurance carrier(s) if they do not respond to payment requests made on my behalf. I understand and agree that I am responsible for any amount not paid by my insurance with the exception of contractual agreements and other disallowed charges. I agree to inform OSC regarding any changes in my personal billing information or my insurance billing information.

Patient/Parent or Guardian Signature: _____ **Date:** ____/____/____