☐ Dr. Becker ☐ _____

Becker Orthopedics

Account # _____
Date _____

Patient Information

Current Complaint _____

Last Name	First	Middle Initial	☐ Smoker ☐ Non Smoker
Address	City	State	Zip
Alternate Address	City	State	Zip
Home Phone	Work Phone	Cell Phone / Pager	E-mail
Sex ☐ M ☐ F	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow	Social Sec.#	Birthdate
Race	Primary Language / Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Spouse name / Spouse Birthdate	Spouse Social Sec.#
Referring Physician	Address		Phone

Responsible Party Information

Name	Date of Birth	Relationship / Employer	Home Phone / Work Phone
Address	City	State / Zip	Social Sec.#

Nearest Relative or Friend Not Living with You

Name	Relationship / Phone
Address	City / State / Zip

Insurance Information

Primary Insurance	Address
Policy holder Name/Employer if Workers' Compensation	ID# / Claim # / Group #
Secondary Insurance/Private Health or Health Insurance	Address
Policy Holder Name	ID # / Claim # / Group #

Accident Information

☐ Auto ☐ Work ☐ Liability	Date of Injury
Attorney Name	Attorney Phone
Attorney Address	City / State / Zip
Insurance Adjuster Name	Phone

Assignment of Benefits and Guarantee of Account
I hereby authorize payment directly to Becker Orthopedics of benefits otherwise payable to me, including major medical insurance, agreeing that this assignment is irrevocable. I also authorize refund to the insurance carrier of overpaid insurance benefits where my coverages are subject to coordination of benefits. I authorize any overpayment due me on this account to be first applied to any other unpaid balance I may have at Becker Orthopedics. I understand that I am financially responsible to Becker Orthopedics for all charges incurred. I agree to pay this account when due.

Signed _____ Date _____

Records Release and Privacy Notice
I hereby authorize Becker Orthopedics to release to my referring physician and insurance company any information, including diagnosis and records of treatment, concerning my past medical history and orthopedic care. I have been provided with a copy of Becker Orthopedics Notice of Privacy Practice.

Signed _____ Date _____

Medicare Patient Signature Authorization
I requested that payment of authorized medicare benefits be made to Becker Orthopedics for any services furnished me by that clinic. I authorize any holder of hospital or medical information, about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed _____ Date _____