ALL ACCESS **ORTHO**

FOR OFFICE USE ONLY			
Account No	Type	Dr. #	Date

LAST NAME		FIRST NAME	MIDDLE NAME
SEX ❑ M ❑ F	DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
PATIENT'S ADDRESS (INCLUDE CITY, STATE AND ZIP CODE			HOME PHONE
GUARANTOR'S NAME & ADDRESS, IF DIFFERENT (INCLUDE CITY, STATE AND ZIP CODE)			CELL/PAGER
EMPLOYER NAME/ADDRESS		OCCUPATION	BUSINESS PHONE
SPOUSE'S NAME		SPOUSE'S EMPLOYER	BUSINESS PHONE
EMERGENCY CONTACT NAME/ADDRESS (someone not living with you)		RELATIONSHIP	PHONE
REFERRING DOCTOR/PRIMARY CARE DOCTOR		PHONE NUMBER	E-MAIL ADDRESS

HAVE YOU BEEN TREATED AT ALL ACCESS ORTHO PRIOR TO TODAY'S VISIT? ❑ YES ❑ NO - IF NO, PLEASE ANSWER BELOW
HOW DID YOU HEAR ABOUT US? ❑ FAMILY MEMBER ❑ FRIEND ❑ PHYSICIAN ❑ YELLOW PAGES ❑ WEBSITE ❑ GOOGLE ❑ YELP ❑ EMPLOYER ❑ INSURANCE ❑ MAIL ❑ SOCIAL NETWORK

If patient is a CHILD, please complete the following:

PARENT/GUARDIAN'S NAME		RELATIONSHIP TO PT	MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
HOME PHONE	BUSINESS PHONE	CELL/PAGER	CHILD'S SCHOOL
PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD			RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

❑ PRIVATE INSURANCE ❑ WORKER'S COMPENSATION ❑ NO-FAULT ❑ TPL

PRIMARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME		SEX ❑ M ❑ F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #		GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME		SEX ❑ M ❑ F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #		GROUP #	COVG CODE
TERTIARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME		SEX ❑ M ❑ F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #		GROUP #	COVG CODE

INJURY INFORMATION

DATE OF INJURY/ONSET	CONDITIONS WE ARE TREATING YOU FOR TODAY
FOR OFFICE USE ONLY	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS
I authorize All Access Ortho, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier. _____ (initial here)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES – Details of your rights and how your medical information will be used and disclosed by All Access Ortho is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been given to you and is posted in the clinic. I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. _____ (initial here)

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by said insurance.
These included deductible, co-payment, cost-share, and/or non-covered benefits. I also agree to pay a late payment fee of 3% a month on any unpaid balance over 90 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I agree to pay a $20.00 processing fee in addition to any bank fees for each returned check. _____ (initial here)

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient/Parent/Guardian Signature _____ Relationship to Patient _____ Date _____