

Central Carolina Orthopaedic Associates

Section I	Patient Information	Date _____
Name:	_____	Date of Birth: _____ SS number: _____
Race:	_____	Ethnicity: _____ Language: _____
Address:	_____	City: _____ State: _____ Zip: _____
Home #	_____	Cell # _____ Work # _____ Name of Employer _____
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
Person to contact in case of emergency _____		Phone _____
Primary or Family Physician _____	Referring Physician _____	
Reason for your visit _____	Is this an on the job injury? _____	

Section II	Responsible Party
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name:	_____ Relationship to Patient: _____
Address:	_____ Phone: (____) _____
City:	_____ State: _____ Zip: _____

Section III	Insurance Information
Name of Insured:	_____ DOB: _____ Relationship to Patient: _____
SSN#:	_____ Name of Employer: _____ Work Phone: (____) _____
Insurance Company:	_____ Grp # _____ ID# _____
----- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No -----	
Please present card(s) to office staff	

Authorization to release information: I hereby authorize CCOA to release information to insurance carriers concerning my illness/injury and treatment. I authorize CCOA to release information as requested by other practices upon my written consent. **Authorization to Pay:** I hereby assign to CCOA any outstanding payments due for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance carrier and that balances not paid within 30 days after the 1st notification may be referred for legal action.

Patient/Guardian Signature: _____ Date: _____