



Clinical Practice Division: Orthopaedic Clinic

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PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S NAME _____ SSN _____ D.O.B. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____ PHONE _____

INSURANCE COMPANY _____

ID # _____ GROUP # _____

EFFECTIVE DATE _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S NAME _____ SSN _____ D.O.B. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____ PHONE _____

INSURANCE COMPANY _____

ID # _____ GROUP # _____

EFFECTIVE DATE _____

I request that payment of authorized Medicare or other Payor benefits be made on my behalf to the physician for any services furnished to me by this facility, realizing that I am responsible to pay non-covered services. I also authorize the physician to release any medical information to the Health Care Financing Administration and its agents or other authorized payors needed to determine benefits or the benefits payable for related services. This authorization will remain in effect until I choose to revoke it.

Signature (patient or parent if minor)

Date