WELLINGTON®
Orthopaedic & Sports Medicine

PATIENT INFORMATION

PATIENT'S FULL NAME	SEX M___ F___	MARITAL STATUS S___M___W___D___SEP___	DATE OF BIRTH	SOCIAL SECURITY NO.
STREET ADDRESS		CITY STATE ZIP		HOME PHONE NO.
PLACE OF EMPLOYMENT		OCCUPATION		BUSINESS PHONE NO.
REFERRED BY	ADDRESS			PHONE NO.
IN CASE OF EMERGENCY, NOTIFY		RELATIONSHIP		PHONE NO. CELL NO.

HAVE YOU BEEN SEEN BY ANY OF OUR PHYSICIANS BEFORE?
YES _____ NO _____

IF SO, BY WHOM? _____

WHY? _____

ARE YOU CURRENTLY WORKING?
YES _____ NO _____

IS YOUR SPOUSE CURRENTLY WORKING?
YES _____ NO _____ N/A _____

IS THIS INJURY THE RESULT OF AN AUTOMOBILE ACCIDENT?
YES _____ NO _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE CO.		POLICY I.D. NO.
ADDRESS		CITY, STATE, ZIP
POLICY HOLDER NAME	EFFECTIVE DATE OF INSURANCE	RELATIONSHIP TO PATIENT
POLICY HOLDER'S D.O.B.	SOCIAL SECURITY NO.	POLICY HOLDER EMPLOYER NAME

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE CO.		POLICY I.D. NO.
ADDRESS		CITY, STATE, ZIP
POLICY HOLDER NAME	EFFECTIVE DATE OF INSURANCE	RELATIONSHIP TO PATIENT
POLICY HOLDER'S D.O.B.	SOCIAL SECURITY NO.	POLICY HOLDER EMPLOYER NAME
POLICY HOLDER EMPLOYER PHONE		POLICY HOLDER EMPLOYER ADDRESS

RESPONSIBLE PARTY

IF RESPONSIBLE PARTY IS SOMEONE OTHER THAN PATIENT PLEASE COMPLETE THE INFORMATION BELOW.

FULL NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
STREET ADDRESS (IF DIFFERENT THAN PATIENT'S)	CITY STATE ZIP	HOME PHONE NO.
PLACE OF EMPLOYMENT		BUSINESS PHONE NO.

ATTORNEY INVOLVED?
YES _____ NO _____

ATTORNEY'S NAME _____

I authorize the release of medical information (which may include treatment for physical/emotional illness, communicable disease, alcohol or drug treatment, and HIV/AIDS related information) to my insurance carrier, employer/employer's representative (workers compensation), or to my physicians listed above for the services rendered at Wellington Orthopaedics & Sports Medicine. I also authorize the release of payment information from my insurance carriers to Wellington Orthopaedics & Sports Medicine.

Date _____ Signature _____