

# BIG RAPIDS ORTHOPAEDICS, PC

Patient Name: \_\_\_\_\_  
*LAST NAME* *LEGAL FIRST NAME* *MIDDLE INITIAL*

If you prefer to be called by a different name, please list here: \_\_\_\_\_

Address: \_\_\_\_\_  
*STREET* *CITY* *STATE* *ZIP*

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Sex:  Male  Female Social Security# \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_

Person to contact in an Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

If patient is a minor:

Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

Date of Injury: \_\_\_\_\_ Workers' Compensation Injury:  No  Yes

In Litigation?:  No  Yes Auto Accident:  No  Yes

Attorney: \_\_\_\_\_ Other Injury (specify): \_\_\_\_\_

### **PRIMARY INSURANCE:**

### **SECONDARY INSURANCE:**

\_\_\_\_\_  
*Insurance company name*

\_\_\_\_\_  
*Insurance company name*

\_\_\_\_\_  
*Subscriber's name*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Subscriber's name*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Policy Number/Group Number*

\_\_\_\_\_  
*Policy Number/Group Number*

\_\_\_\_\_  
*Social Security Number*

\_\_\_\_\_  
*Social Security Number*

\_\_\_\_\_  
*Employer*

\_\_\_\_\_  
*Employer*

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## **RELEASE AND ASSIGNMENT OF BENEFITS**

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO BIG RAPIDS ORTHOPAEDICS, PC, TIN# 38-2020732. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. A COPY OF THIS SIGNATURE AND STATEMENT SHALL BE AS VALID AS THE ORIGINAL.

\_\_\_\_\_  
*SIGNATURE*

\_\_\_\_\_  
*DATE*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**MEDICATIONS**

Drug & Strength	Times /Day	Reason for taking Medication	Drug & Strength	Times /Day	Reason for taking Medication

**ALLERGIES**

Allergies	Reaction	Allergies	Reaction

**FAMILY HISTORY**

Member	Alive	Deceased	Age	Health Status or Cause of Death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D *		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

**SOCIAL HISTORY**

Work in the home     Employed     Student     Daycare     Retired  
 Single     Married     Divorced     Separated     Widowed  
 Children?     No     Yes # \_\_\_\_\_  
 Do you live alone?     No     Yes  
 Exercise?     Weekly     Monthly     Rarely     Never  
 What type of exercise? \_\_\_\_\_  
 History of substance abuse?     No     Yes What? \_\_\_\_\_  
 Smoke currently?     No     Yes \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.  
 Quit smoking?     This year     >1 year     >5 years     >10 years  
 Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years.  
 Drink Alcohol?     Daily     1-2 times per week     1-2 times per month     1-2 times per year  
 Drink Coffee?     No     Yes \_\_\_\_\_ Cups per day  
 Other Caffeine?     No     Yes \_\_\_\_\_ Servings per day

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed: \_\_\_\_\_ Reviewed: \_\_\_\_\_

Reviewed: \_\_\_\_\_ Reviewed: \_\_\_\_\_