Orthopedics & Joint Replacement @ Mercy

Account #: _____
(Office Use)

Patient Demographic Sheet

Date: _____ S. S. # _____ - _____ - _____

Last Name: _____ Suffix: _____ First Name: _____ MI: ___

Driver's License #: _____ Birth Date: _____/_____/_____ Gender: Male Female
(Circle One)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)_____-_____ Work Phone (____)_____-_____

Cell Phone: (____)_____-_____ Email Address: _____

Marital Status: Single Married Widowed Divorced Spouse's Name: _____
(Circle One)

Emergency Contact: _____ (____)_____-_____
(Name) (Phone)

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Please describe reason for visit: _____

Date of Onset: _____/_____/_____

Referred By: _____ Phone: (____)____- _____

Primary Physician: _____ Phone: (____)____-_____

How did you hear about us?_____

Please note: Due to many insurance billing problems we *must* have either a referring doctor's name & phone number or your family physician's name and phone number.

Notice: Referrals/Authorizations are the responsibility of the patient. If your insurance company requires a referral/authorization, you *must* have your referral/authorization at the time of your visit in order to be seen. Failure to do so may result in a rescheduled appointment. *We will not phone your primary care physician to obtain your referral/authorization.*

*** Please keep your insurance card(s) and driver's license/photo i.d. out for photocopies * ***

Insurance Information

Primary Insurance: _____ Phone: (____)____-_____

Are referrals/authorizations required? Yes No Co-Pay Amt.: $_____
(Circle One)

Claim Address: _____

Policy Holder: _____ Relationship: _____
(Name)

Policy Holder's DOB: _____/_____/_____ S.S. #: _____ - _____ - _____

Policy Holder's Employer: _____

Policy Holder's Employer Phone: (____)-_____-_____ X _____

Membership #: _____ Group #: _____

Secondary Insurance: _____ Phone: (____)____-_____

Are referrals/authorizations required? Yes No Co-Pay Amt.: $_____
(Circle One)

Claim Address: _____

Policy Holder: _____ Relationship: _____
(Name)

Policy Holder's DOB: _____/_____/_____ S.S. #: _____ - _____ - _____

Policy Holder's Employer: _____

Policy Holder's Employer Phone: (____)-_____-_____ X _____

Membership #: _____ Group #: _____

Workers Compensation, Accidents, Etc.

Bill to: _____
(Name Of Insurance Co.) (Address)

Accident or Illness onset date: _____/_____/_____ File/Claim #: _____

Adjuster: _____ (_____)_____ - _____
(Name) (Phone)

Address to send bills: _____

Accident Description: _____ Accident State _____

Employer at the time of accident: _____