

MT TAM ORTHOPEDICS
Orthopedic Surgery and Sports Medicine

Patient Information

Male Female Marital Status: _____ Date Today: _____ Date of Injury: _____
Name: _____ Date of Birth: _____ Age: _____
Mailing Address: _____ Home Phone # _____
City: _____ State: ___ Zip: _____ Work Number # _____
Social Security: _____ Pharmacy & City Location: _____
Employer: _____ Occupation: _____
Employer Address: _____ City: _____ Zip: _____
Spouse/Parent Name: _____ Phone # _____
In Case of Emergency Notify: _____ Phone # _____

IT IS A FEDERAL REQUIREMENT THAT MT TAM ORTHOPEDICS REPORTS THE FOLLOWING:

*Race: Hispanic or Latino *Ethnicity: American Indian or Alaska Native White
 Not Hispanic or Latino Asian Decline to State
 Decline to State Native Hawaiian or other Pacific Islander
 Black or African American

*Preferred Language: _____

* This information will be held confidential and only a limited number of people will have access to the data.

Insurance Information

How are you planning on paying for your visit today with the doctor (check **ONE** only)

Medical Insurance: _____ Workman Compensation Insurance/Claim: _____
Privately Paying/Cash: _____ Motor Vehicle Insurance/Claim: _____

Subscriber or Policy Holder: _____ Subscriber Birth date: _____
Name as it appears on insurance card: _____
Relationship to subscriber/insured: _____ Subscriber Social Security # _____
Insurance Carrier: _____ Phone # _____
Claim Address: _____ City: _____ State: ___ Zip: _____
Insurance I.D.# _____ Group/Plan # _____
Secondary Insurance: _____
Primary Care Physician (PCP): _____ Injured Body Part: _____
Sports/Hobbies/Activities: _____
Special Needs: _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to my physician (Mt. Tam Orthopedics). I understand I am financially responsible for non-covered services and also authorize my physician to release any information required.

Patient Signature

Date