

PLEASE PRINT

PATIENT REGISTRATION – GIKK ORTHO SPECIALISTS

Doctor _____ Date _____ Acct.# _____

PATIENT LEGAL NAME _____

Address _____ (Last) _____ (First) _____ (Middle) _____
City _____ State _____ Zip _____

Phone Home (____) _____ Work (____) _____ Cell (____) _____ Email Address _____

SS# _____ Age _____ Birth Date _____ Sex ____ M ____ F

Student Status () Full time () Part time School _____

Employer _____ Phone (____) _____

S M D W If Married: Spouse's Name _____
Spouse's Employer _____ Phone (____) _____

If Minor or Student (covered under parents insurance)
Mother _____ Employer _____ Phone (____) _____
Father _____ Employer _____ Phone (____) _____

Emergency Contact _____ Phone (____) _____

Referred by /Self / Family / Friend / Physician (please choose one)

Referring Physician _____ Address _____

Family Physician _____ Address _____

I authorize you to send clinic records to above physicians. Yes / No Please sign _____

BILLING INFORMATION

Primary Ins. Co. _____ Policy # _____ Group # _____

Policyholder _____ SS# _____ Birth Date _____ Sex ()M ()F

Secondary Ins. Co. _____ Policy # _____ Group # _____

Policyholder _____ SS# _____ Birth Date _____ Sex ()M ()F

Responsible Party _____

Address _____ City _____ State _____ Zip _____

Assignment and Release: I hereby assign my insurance benefits to be paid directly to Drs. Gross, Iwersen, Kratochvil & Klein, P.C. I also authorize the physician to release any information requested by my insurance company. I understand I am financially responsible for all charges not covered by this assignment.

Signature _____ Date _____

MEDICAL INFORMATION

Reason for Seeing Doctor _____ Date of Injury/Illness _____

Similar conditions in the past? Yes No When _____ X-rays/tests performed? Yes No What kind? _____
If injury, is it Job Related? Yes No Auto Accident? Yes No Other Accident? Yes No

If Job Related, Employer _____ Occupation _____

Employer's Address _____ Phone (____) _____ Fax (____) _____

Claim to be sent to: _____

Insurance Adjuster/Address _____

Phone (____) _____ Fax (____) _____ Claim # _____

Case Manager Name/Address _____

Phone (____) _____ Fax (____) _____

Authorization date _____ by _____ Authorization date _____ by _____

Authorization date _____ by _____ Authorization date _____ by _____