SAN MARCOS ORTHOPEDICS

Please Print Information / Fill in all Blanks

PATIENT INFORMATION

Patient Name (Last, First, Middle)	Social Security #	Sex M or F	Marital Status
Email Address for Web Portal **(OPTIONAL)**			Language Preferred
Address	Phone #	Age	Date of Birth
City-State-Zip	Cell #	Occupation	

Employer Name	Address	City-State-Zip
Family Physician	Referred By	If patient is a student, Name of School

In Case of Emergency Notify	Relationship	Phone #

PHARMACY INFORMATION

Pharmacy Name	Address	City	Phone #

INSURANCE INFORMATION

Primary Insurance Policy Holder	Relationship	Social Security #	Phone #
Date of Birth	Address	City-State-Zip	
Employer Name	Address	Phone #	

Secondary Insurance Policy Holder	Relationship	Social Security #	Phone #
Date of Birth	Address	City-State-Zip	
Employer Name	Address	Phone #	

In the event this claim is denied by my insurance company I understand that I am responsible for all charges incurred as a result of this visit. I hereby authorize the above physician to release information to my employer and insurance carrier. I hereby authorize payment directly to the above provider of the surgical and medical benefits if any, otherwise payable to me for his services, but not exceed the reasonable and customary charges for all those services. I understand that this authorization does not release me from my personal responsibility for payment of all charges.

Signed (Patient or Insured) (Parent signature required for minors)

Signature _____ Date _____

OFFICE USES ONLY	
Insurance Verification	
Effective Date:	
Co-Pay Amt:	
Deductible Amount Met:	
Deductible Amount Met:	OOP Amount Met:

DME Coverage:

Insurance Benefits	
Patient Name:	Insurance Name:
Eff Date:	Ins Type (HMO, PPO):
OV Copay:	% paid at:
Deductible:	Deductible Met:
% pd at after meeting deduct:	DME benefits: