

Chart No. _____

Acct. No. _____

Dr. _____
(For Office use only)

CAMDEN BONE & JOINT, LLC

PATIENT HISTORY (Please Print)

Date _____

Last Name _____ First _____ MI _____

- MARRIED
- SINGLE
- WIDOWED
- DIVORCED
- SEPARATED

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Sex _____ Home Phone No. () _____ Work No. () _____

Social Security No _____ Age _____ Date of Birth _____ Weight _____ Height _____

(For Office use only) Date Received _____ Date Sent to Insurance _____ Initials _____

IN THE EVENT OF SURGERY OR FRACTURE TREATMENT, THE PATIENT IS RESPONSIBLE FOR BRINGING IN COMPLETED & SIGNED INSURANCE FORM

Person responsible for paying this bill Self Other _____

Primary Insurance _____ ID/Policy No. _____ Group No. _____

Name of Insured _____ Insurance Address _____

Secondary Insurance _____ ID/Policy No. _____ Group No. _____

Name of Insured _____ Insurance Address _____

If Covered under Spouse's Insurance - Please give Spouse's DOB _____ SSN _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY CAMDEN BONE & JOINT, LLC, AS NECESSARY TO PROCESS ANY INSURANCE CLAIM AND REQUEST PAYMENT OF BENEFITS TO CAMDEN BONE & JOINT, LLC FOR SURGERY, FRACTURE FEE OR ANY UNPAID BILLS.

Signature _____ Relationship to Patient _____ Date _____

Patient's Occupation _____

Patient's Employer _____ Employer Phone # _____

Employer Address _____ Injured @ Work? _____

Spouse's Name _____ Employer Phone # _____

Spouse's Employer & Address _____

Nearest Relative other than above: Name _____ Address _____

(with Telephone) City _____ State _____ Zip _____ Phone # () _____

Has patient ever been treated by any Camden Bone & Joint physician before? _____ If "yes" when _____

Give full name of referring physician _____ Address _____

What medications does patient take regularly _____ Is patient

allergic to any medications that you know of _____ If "yes" give name _____

Has patient been seen or treated for present problem _____ If "yes" When _____

Where (or by whom) _____

Has patient had X-Rays taken for this problem _____ If "yes" When _____

Where _____ Do you have them with you _____

★ Specific part of the body that is causing problem _____

Date of Accident or onset of problem _____ If injury, or accident how did it happen _____

Where _____