

Chart No. _____

Acct. No. _____

Dr. _____
(For Office use only)

CAMDEN BONE & JOINT, LLC

PATIENT HISTORY (Please Print)

Date _____

Last Name _____ First _____ MI _____

Address _____

Phone # () _____ Date of Birth _____ Age _____ Sex _____

Social Security No. _____ Weight _____ Height _____

- MARRIED
- SINGLE
- WIDOWED
- DIVORCED
- SEPARATED

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 Father Mother Spouse Other _____

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

Name of Insured _____ Home Address _____

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

Name of Insured _____ Home Address _____

Primary Insured's DOB _____ SSN _____ Employer _____

Secondary Insured's DOB _____ SSN _____ Employer _____

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 _____

Father's Information

Name _____ Employer _____

Address _____ Address _____

City _____ State _____ City _____ State _____

Zip _____ Phone # () _____ Zip _____ Phone # () _____

DOB _____ SSN _____

Mother's Information

Name _____ Employer _____

Address _____ Address _____

City _____ State _____ City _____ State _____

Zip _____ Phone # () _____ Zip _____ Phone # () _____

DOB _____ SSN _____

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 _____ Phone # () _____

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" Where _____

Has patient had X-Rays taken for this problem _____ If "yes" Where _____ Did you bring films? _____

★ Specific part of the body that is causing problem _____ Injured @ work? _____

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

Where _____