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**South Metro
 Bone & Joint, P.C.**

PATIENT INFORMATION FORM

Patient's Full Name: _____ Age: _____
 Birthdate: _____ Sex: _____ Marital Status: _____
 SS#: _____ Home Phone:() _____ Cell Phone:() _____
 Street Address: _____ Apt/Lot#: _____
 City: _____ State: _____ Zip Code: _____
 Employer: _____ Position: _____
 Employer's Street Address: _____ Work #: _____
 City: _____ State: _____ Zip Code: _____
 Spouse Name: _____ SS#: _____
 Spouse Birthdate: _____ Employer: _____
 Position or Dept.: _____

If Patient is a minor:

Father's Name: _____ DOB _____ SS# _____
 Father's Employer: _____ Work # _____
 Mother's Name: _____ DOB _____ SS# _____
 Mother's Employer: _____ Work # _____

Person to contact in case of Emergency, (not living with you)

Name: _____ Relationship: _____
 Home # () _____ Work # () _____ Address: _____

Who referred you to us? _____ Family Dr. _____

**PLEASE GIVE RECEPTIONIST ALL INSURANCE CARDS FOR COPYING.
 IF WORKER'S COMPENSATION GIVE A CONTACT NAME AND A PHONE NUMBER.**

I hereby authorize South Metro Bone and Joint, P.C. to release any medical information necessary to process a claim for services rendered. I further authorize assignment of benefits directly to physician. I understand that I am responsible for payment of services not covered by Insurance. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient or Authorized Person (Signature) _____ **Date** _____