

# BLUE RIDGE ORTHOPAEDICS AND SPORTS MEDICINE, P.A.

Date: \_\_\_\_\_

Chart #: \_\_\_\_\_

Provider: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
(First) (Middle) (Last)  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone # \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_  
 Alternate# \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Student (Y/N) Full \_\_\_ Part \_\_\_  
 Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
 How did you hear about our practice? Newspaper \_\_\_ Radio \_\_\_  
 Doctor Referral \_\_\_ Friend \_\_\_ Other \_\_\_

Blue Ridge Orthopaedics and Sports Medicine may have to contact you at your home regarding prescriptions or appointments. Checking this box indicates your authorization to leave the information on your home answering machine or with anyone at home.  
 Yes \_\_\_ No \_\_\_  
 If No, List here those to whom this information may be given:

Pharmacy: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
 Relationship \_\_\_\_\_ Phone No. \_\_\_\_\_

Referring Doctor \_\_\_\_\_  
 Family Doctor \_\_\_\_\_

## Guarantor Information (Personal Responsible for paying balance) Same as Above

Guarantor Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone No. \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Social Security No. \_\_\_\_\_

Employed By \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone No. \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

## FATHER INFORMATION (If different from above) Responsible for Payment: Yes No

Father's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone No. \_\_\_\_\_ Birth Date \_\_\_\_\_

Employed By \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone No. \_\_\_\_\_ Social Security # \_\_\_\_\_

## MOTHER INFORMATION (If different from above) Responsible for Payment: Yes No

Mother's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone No. \_\_\_\_\_ Birth Date \_\_\_\_\_

Employed By \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone No. \_\_\_\_\_ Social Security # \_\_\_\_\_

## INSURANCE INFORMATION

Name of **Primary** \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_  
 Policy Holder Birthdate \_\_\_\_\_  
 Policy Holder Social Security No. \_\_\_\_\_

Name of **Secondary** \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_  
 Policy Holder Birthdate \_\_\_\_\_  
 Policy Holder Social Security No. \_\_\_\_\_

### Reason for Visit

I HEREBY CONSENT TO TREATMENT FOR MYSELF, MY CHILD, OR THE ABOVE NAMED MINOR, FOR WHOM I ACCEPT RESPONSIBILITY. THE RELEASE OF MEDICAL INFORMATION TO ANY INSURANCE CARRIER AND DIRECT PAYMENT TO BLUE RIDGE ORTHOPAEDICS AND SPORTS MEDICINE, P.A. FOR ANY TREATMENT OR EXAMINATION RENDERED IS AUTHORIZED. I HEARBY ACKNOWLEDGE AND ACCEPT FINAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR MEDICAL SERVICES RENDERED. THIS AUTHORIZATION IS CONSIDERED VALID FOR ALL DATES OF SERVICE UNTIL SUCH AUTHORIZATION IS REVOKED.

**SIGNATURE (PATIENT OR GUARDIAN OF PATIENT) X** \_\_\_\_\_

**(SEAL)** \_\_\_\_\_