PONTCHARTRAIN BONE AND JOINT CLINIC, LTD.
PATIENT INFORMATION

(PLEASE PRINT LEGIBLY - MEDICAL RECORDS DATA)

PATIENT'S NAME: (LAST FIRST MIDDLE)	DATE OF BIRTH	AGE	MARITAL STATUS S M W D SEP	SEX F M	SOCIAL SECURITY NO.

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG	WORK PHONE

DRUG ALLERGIES	CELL PHONE

REFERRED BY:	PRIMARY CARE PHYSICIAN:

SPOUSE'S NAME	EMPLOYER	WORK #

FATHER'S NAME	EMPLOYER	WORK #

MOTHER'S NAME	EMPLOYER	WORK #

PERSON TO NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP	WORK / HOME #

DATE OF INJURY	WAS AN AUTOMOBILE INVOLVED?	WERE YOU INJURED ON THE JOB?	EMPLOYER AT TIME OF INJURY

WERE X-RAYS TAKEN OF THIS PROBLEM? YES NO	WHERE?	DATE X-RAYS TAKEN

PARTY RESPONSIBLE FOR PAYMENT	D.O.B. / /	ADDRESS, STREET, CITY & ZIP CODE	PHONE #

PRIMARY INSURANCE COMPANY	POLICY HOLDER'S NAME	SOCIAL SECURITY NO.

OTHER INSURANCE COMPANY	POLICY HOLDER'S NAME	SOCIAL SECURITY NO.

OFFICE USE ONLY

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Pontchartrain Bone and Joint Clinic, Ltd. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

Certain physician members of Pontchartrain Bone and Joint Clinic have an ownership interest in either East Bank Imaging, St. Charles Surgical Hospital or Greater New Orleans Surgery Center. These physicians have become owners as a result of their commitment to quality health care and to assure proper service to their patients. I understand that my physician may have an ownership interest in a facility to which I may be referred and that I have the right to obtain medical services at a facility of my choice.

Date: _____ **Signature** _____