STEAMBOAT ORTHOPAEDIC ASSOCIATES, P.C.

ACCIDENT/SYMPTOM INFORMATION
For New and Existing Patients

Patient's Name: ____ Today's Date: ____________________

Date of Injury:___________________ Referring Physician: ____

What are we seeing you for today? ____ ☐ Right ☐ Left

How and where did the injury occur? ____

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If no specific injury, when did you first notice onset of symptoms? _____________________________________

Did the injury or symptoms originate on the job? ☐ Yes ☐ No

What insurance is involved?

☐ Personal Health: Please provide copy of card. If no card available, please fill out the following:

Company: ____ ID#: ___________________________

Address: ____ Group #: __________________

☐ Workers' Comp Company: _______________________________ Claim #: ________________________

Address: ____ Phone: ___________________

Adjuster: ____ Fax: _____________________

☐ Motor Vehicle Company: _________________________________ Claim/Policy #: __________________

Address: ____ Phone: ___________________

☐ 3rd Party Liability Company: _____________________________ Claim/Policy #:__________________

Address: ____ Phone: ___________________

☐ Self Pay: Payment is appreciated at the time of service.

- I consent to treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I allow fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered to the above named patient.
- I understand that payment of charges incurred is due at the time of service unless other financial arrangement have been made prior to treatment.
- I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
- I further authorize and request that all insurance payments be made directly to my treating physician.
- I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

____ ________________________

Signature of patient/parent/or authorized representative Date