

Patient Last Name	Patient First Name	M.I.	Date of Birth:	Sex: M F
Address:		City	State	Zip
Home Phone#	Cell Phone	Social Security		
Marital Status:	Employment Status: FT PT Retired Unemployed Student	Employer:		
Employer Address:		Employer Phone:		
Guarantor Last Name:	Guarantor First Name:	MI	Date of Birth:	Sex M F
Address:		City	State	Zip
Home Phone#	Cell Phone	Social Security		
Primary Insurance Company Name		Subscriber Name		
Subscriber Date of Birth		Subscriber Social Security Number		
Secondary Insurance Company Name		Subscriber Name		
Subscriber Date of Birth		Subscriber Social Security Number		
Type of Injury/Symptom:				
Is this a result of an injury?		Yes	No	Date of Injury (REQUIRED):
Was Your Injury:		Work Related	Yes No	Auto Accident Yes No
Emergency Contact Person Name:		Relationship		
Phone Number		Date form completed		

In conjunction with services provided by Orthopedic Specialty Clinic, Ltd., I authorize the release of my medical/financial information via phone, fax or mail to facilities and/or contractors to which Orthopedic Specialty Clinic is affiliated; including but not limited to Mary Washington Hospital, Fredericksburg Ambulatory Surgery Center and Insurance Companies. The undersigned agrees to be ultimately responsible for payment for all charges for services rendered by Orthopedic Specialty Clinic, whether such services are covered by insurance benefits. I agree to pay collection costs and reasonable attorney fees incurred as a result of outstanding account balances. I understand there will be a \$50.00 returned check fee for all checks returned for insufficient funds.

It is the policy of Orthopedic Specialty Clinic to call the phone numbers you have provided in order to confirm appointments, return messages and notify you of prescription refills. We will, for your convenience, leave a message if you are unavailable.

Signature of Patient or Authorized Representative