DHALLA ORTHOPEDIC CENTER INC.

PLEASE PRINT

(OFFICE USE ONLY)	ACCOUNT TYPE	DR. NO.	ACCOUNT NO.	DATE

NEW PATIENT INFORMATION (PLEASE PRESS FIRMLY)

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

E-MAIL

STREET ADDRESS PERMANENT	CITY AND STATE	ZIP CODE	HOME PHONE NO.

RESPONSIBLE PARTY (FAMILY) NAME IF OTHER THAN ABOVE	DRIVER LIC. NO	SOCIAL SECURITY NO.

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.

EMPLOYER OF PATIENT OR RESPONSIBLE PARTY IF MINOR	OCCUPATION (INDICATE IF A STUDENT)	BUS. PHONE NO.

SPOUSE NAME	EMPLOYER	OCCUPATION	BUS. PHONE NO.

IN CASE OF EMERGENCY, NOTIFY:

REFERRING/ PRIMARY DOCTOR	STREET ADDRESS, CITY, STATE & ZIP CODE	PHONE NO.

INSURANCE INFORMATION

MEDICARE ❑	MEDICARE NUMBER #	MEDI-CAL ❑	MEDI-CAL NUMBER #

NAME OF INSURANCE COMPANY (PRIMARY)	SECONDARY/SUPPLEMENTAL INSURANCE COMPANY
STREET ADDRESS	STREET ADDRESS
CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE
GIVE NAME OF POLICYHOLDER	GIVE NAME OF POLICYHOLDER

GROUP/POLICY NO.	SUBSCRIBER/I.D. NO.	GROUP/POLICY NO.	SUBSCRIBER/I.D. NO.

❑ ACCIDENT	❑ AUTO/VEHICLE ❑ OTHER.	CLAIM NUMBER:	DATE OF INJURY:

WORK COMP INFORMATION

WERE YOU INJURED ON THE JOB? ❑ YES ❑NO	DATE OF INJURY	INDUSTRIAL CLAIM NUMBER

NAME OF WORKMAN'S COMPENSATION CARRIER	ADDRESS. CITY AND STATE	ZIP CODE

PERSON TO CONTACT	BUS. PHONE NO.	HAVE YOU SEEN A PHYSICIAN FOR THIS INJURY? ❑ Yes ❑ No

PLEASE SIGN THE FOLLOWING FORM

I HEREBY AUTHORIZE DHALLA ORTHOPEDIC CENTER, INC., TO RELEASE MY MEDICAL/PERSONAL INFORMATION TO INSURANCE COMPANY OR TO A DESIGNATED ATTORNEY. ALL INFORMATION WHICH THE INSURANCE COMPANY OR ATTORNEY MAY REQUEST. I HEREBY ASSIGN DHALLA ORTHOPEDIC CENTER INC. ALL BENEFITS PAID DIRECTLY BY INSURANCE. IT IS UNDERSTOOD THAT ANY PAYMENT RECEIVED FROM THE INSURANCE COMPANY, OVER AND ABOVE MY INDEBTEDNESS WILL BE REFUNDED TO ME WHEN MY BILL IS PAID IN FULL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE, WHETHER MY INSURANCE COMPANY PAYS OR NOT, FOR ALL COSTS INCURRED BY ME. I FURTHER AGREE THAT IN THE EVENT OF NON-PAYMENT, I WILL BEAR THE COST OF COLLECTION AND/ OR COURT COST AND REASONABLE LEGAL FEES SHOULD SUCH COURT ACTION BE REQUIRED. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

_____ INSURED OR GUARDIAN SIGNATURE

_____ PATIENT'S SIGNATURE