

WARDELL ORTHOPAEDICS, P.C.

Patient Information

Office Use Only

<input type="checkbox"/> New Patient	Check in _____	Recp. Name _____	Patient ID (Greenway #) _____
<input type="checkbox"/> Est./New Complaint	Papers Rec'd _____	Preferred Provider	Other ID (W.O. #) _____
<input type="checkbox"/> Info / Ins. Change	Appt Time _____	Wardell	

Preferred Pharmacy

Pharmacy Name _____ Address _____
 Phone # _____ Fax# _____

Patient Information

Name _____ Maiden / Other Name _____
Last First Middle

Prefix Miss Mr. Mrs. Ms. Dr. Suffix I II III IV Jr. Sr. Patient's Social Security # _____

AGE _____ Date of Birth _____ Sex: Male Female

Race: African American/Black American Indian/Alaskan Native Asian Nat Hawaiian/Pacific Islander White-Caucasian Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined Marital Status _____

Physical Address _____ Apt # _____ Zip _____ City _____ State _____
 Mailing Address _____ Apt # _____ Zip _____ City _____ State _____
(If same as above, continue to Home #)

Cell #: _____ Home #: _____ Work #: _____

Email: _____ Preferred Method of Communication Home # Cell #
 For Appointment Reminder Calls: Text #

Required for Patient Portal Access

Employer

OCCUPATION _____ Patient's Employer _____ Employer Phone _____

Patient Status: Full-Time Part-Time Self-Employed Active Military Duty Retired
 Full-Time Student Part-Time Student Unemployed Disabled Other

Responsible Party Information

If self, move to Emergency Contact section. If parent, legal guardian or legal custodian, please complete this section in full.

Relationship to Patient: Mother Father Legal Guardian Other _____

Name _____ Social Security # _____
Last First Middle

Address _____ City _____ State _____ Zip _____
 Home # _____ Cell # _____ Employer's Name _____ Employer's # _____

Emergency Contact

In Case of Emergency, Please Notify: _____
 Home # _____ Cell # _____ Relationship _____

Primary Insurance Coverage

Insurance Company Name _____ Ins.Co.Phone _____ Effective Date _____
 Policy Holder's Name _____ SS# _____ Relationship to Patient _____
 Subscriber ID# _____ Subscriber DOB _____ Subscriber Employer _____

Secondary Insurance Coverage

Insurance Company Name _____ Ins.Co.Phone _____ Effective Date _____
 Policy Holder's Name _____ SS# _____ Relationship to Patient _____
 Subscriber ID# _____ Subscriber DOB _____ Subscriber Employer _____

Authorization

I AUTHORIZE Wardell Orthopaedics, P.C. (WO, P.C.) to release any medical information necessary to submit my insurance or workers' compensation claims. I request that my insurance or workers' compensation claims pay benefits directly to WO, P.C. In consideration of the services to be rendered, I/we agree and understand that each person(s) signing this document jointly and severally agrees to pay for all services rendered by WO, P.C. I take full responsibility for assuring that my insurance companies are properly notified in the event second opinions, pre-certifications, or pre-admission authorizations are obtained prior to services rendered. I authorize photocopies of this form to be as valid as the original. This is to inform you that Wardell Orthopaedics, P.C. will check the PMP Data Center website for treatment history with controlled substances. I authorize Wardell Orthopaedics, P.C. to access my medication history using Pharmacy Benefit Management (PBM) thru Greenway Health EHR.

Patient or Responsible Party Signature _____ Date _____
 Name or Responsible Party Printed (if not the patient) _____ Relationship _____

WARDELL ORTHOPAEDICS, P.C.

Collection Authorization

Today's Date _____

Patient Name _____

Name _____
Last First Middle

Office Use Only _____

Patient ID
(Greenway #) _____

Other ID
(W.O. #) _____

Authorization _____

I AUTHORIZE Wardell Orthopaedics, P.C. (WO, P.C.) to release any personal or financial information necessary for collections. If this account is referred to an attorney for collection then the undersigned person(s) promise and agree to pay all collection costs including attorney fees of 33 1/3% of the principal amount due and owing when turned over for collection and do further agree to pay interest at 1 1/2% per month (18% per Annum) on the unpaid balance from the date services were last rendered. I authorize photocopies of this form to be as valid as the original. In the event this matter is turned over for collection, I hereby expressly give permission for my current employer(s) to provide verification of my said employment to this office, or their attorney, Tiffany & Brown, P.L.L.C.

Patient or Responsible Party _____

Patient or Responsible Party Signature _____

Name of Responsible Party Printed (*if not the patient*) _____

Relationship _____