WARDELL ORTHOPAEDICS, P.C.

Patient Information

Office Use Only

☐ New Patient
☐ Est./New Complaint
☐ Info / Ins. Change

Check in _____
Papers Rec'd _____
Appt Time _____

Recp. Name _____
Preferred Provider
Wardell Harrell

Patient ID (Greenway #) _____
Other ID (W.O. #) _____

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 #**)

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

Fax # _____ **Email:** _____
Required for Patient Portal Access

Preferred Method of Communication: ☐Home # ☐Work # ☐Cell #

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 ☐ 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

Office Use Only

Patient ID
(Greenway #)_____

Other ID
(W.O. #) _____

Patient Name

Name_____
Last *First* *Middle*

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 ½% 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 & Tiffany, P.L.L.C.

Patient or Responsible Party

Patient or Responsible Party Signature_____

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

Relationship _____