Vermont Orthopedic Clinic
Patient Information

PATIENT INFORMATION (please print) Reference # ________________________

Name:____ Date of Birth:_______________Age_______
Last First M.I.

Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F SS # __ __ __/__ __/__ __ __ __

Mailing Address:____

Home Phone # (_____)______________________ E-Mail Address:____

Current Employer:____Employer Phone _________________________

Employer Address:____

If patient is a minor, person responsible for the bill:____

Address: (if different from the patient) ____
(P.O. Box or Street) Town/State/Zip

Phone Number: (if different than patient) (_____)___________________________

Emergency Contact:_______________________Phone: (___)_______________Relationship:______________________

Is this visit result of an injury? ☐ Y ☐ N

Auto?________Date of Injury______________ Body part___________________

Work? _______Date of Injury_____________ Body part___________________

Other?_______Date of Injury_____________ Body part___________________

If not, onset date____________________

**** IF WORKER'S COMPENSATION INJURY, PLEASE MAKE SURE EMPLOYER INFORMATION IS COMPLETED ABOVE *****

If injury did not occur for current employer, please list below:

Employer:_______________________________________ Phone #: (___)___________________________

Address: ____
(P.O Box or Street) Town/State/Zip

Physician you are seeing here today____

Were you referred to our office? ☐ Y ☐ N Referring Dr's ____
Last First

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Vermont Orthopedic Clinic
Insurance Information

INSURANCE INFORMATION

Please complete insurance information below and **present your insurance card** to our receptionist when your forms are completed. If you do not have your insurance cards with you at the time of your visit then we will consider the patient responsible for payment until a copy of the Insurance card is received.

☐ BCBS ☐ Cigna/PPO ☐ MVP ☐ CBA ☐ Great West ☐ Medicare ☐ Medicaid/PC Plus ☐ Other

(Name/Address)____

Auto Insurance (Name/Address)____

Certificate #___________________________________ Group # ______________________________

Name of Subscriber______________________________ Subscriber date of birth__________________

Subscriber SS# __ __ __ /__ __ / __ __ __ __

Relationship to patient: **(check one)** ☐ Self ☐ Spouse ☐ Child ☐ Other

*OFFICE BILLS COMMERCIAL INSURANCE COMPANIES ELECTRONICALLLY. IF YOUR INSURANCE DOES NOT ACCEPT ELECTRONIC CLAIMS YOU WILL BE ASKED TO SUBMIT THE CLAIMS DIRECTLY. PAYMENT IS REQUESTED AT **30 days** REGARDLESS OF INSURANCE STATUS.*

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I AUTHORIZE THE DIAGNOSIS AND TREATMENT OF MY MEDICAL CONDITION AS MAY BE ADVISABLE FOR MY MEDICAL WELL BEING AND ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED AS A RESULT OF SUCH TREATMENT. I ALSO AUTHORIZE PAYMENT DIRECTLY TO THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED AND THE RELEASE OF RECORDS NEEDED TO PROVIDE THE CLAIM. IF YOUR INSURANCE REQUIRES A REFERRAL AND ONE IS NOT RECEIVED, THEN THE SUBSCRIBER IS RESPONSIBLE FOR THE BILL.

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SIGNATURE **TODAY'S DATE**

******PLEASE MAKE SURE ALL INFORMATION IS COMPLETED ABOVE TO ENSURE PROPER BILLING******

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