Orthopaedic Associates of Osceola

604 Oak Commons Blvd.
Kissimmee, FL 34741
(407) 846-6004

Patient Name ______________________________ Date of Birth ______________
Last First Middle Initial

Street Address ______________________________
Number & Street City State Zip

Mailing Address or Alternate Address ______________________________
Number & Street City State Zip

Home Phone # ( ) __________ Cell Phone # __________ Work Phone # __________

Sex______ ( ) Child ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Soc. Sec. #______-______-______ Email Address ______________________________

Employer/School ______________________________
(Name of School, if child is the patient)

Employer's Address ______________________________ Phone ( ) __________

Parents &/or Spouse's Name ______________________________ Relationship __________

Employer ______________________________ Phone ( ) __________

Employer's Address ______________________________ SS #______-______-______

Nearest relative not living with you:

______________________________ ( ) __________
Name Address Phone

INSURANCE INFORMATION

( ) Medicare ( ) Auto Ins. ( ) Worker's Comp. ( ) Other Insurance

Name of Insurance Company ______________________________ Group # __________

Person Who Carries Insurance ______________________________ I.D. # __________

Date of Birth __________ Soc Sec # __________ Employer __________

Is the patient covered by any other insurance plan? ( ) Yes ( ) No If yes, Name of Insured __________

Name and address of other insurance company ______________________________

Group # ______________________________ I.D. # ______________________________

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I also authorize the physicians at Orthopaedic Associates of Osceola to release any information (via facsimile, mail or phone) acquired in the course of my examination or treatment to other physicians, etc. for health reasons. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. I hereby "Assign any Benefits" from insurance coverage for medical services to Orthopaedic Associates of Osceola. In the event legal action should become necessary to collect unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

Signature of Responsible Party: ______________________________ Date: __________

REORDER # 00-07772-30