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Orthopaedic Medicine
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Patient Name: _____ Age: _____ Sex: _____

Patient Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____ Drivers License #: _____

Patient Home #: _____ Cell #: _____

Patient Work #: _____ Social Security #: _____

Patient Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: _____ **Spouse Name:** _____

Spouse Cell #: _____ **Spouse Work #:** _____

Patient Occupation: _____ Name of Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Who referred you to this office? _____ How are you related: _____

Phone #: _____ Cell #: _____

Who to notify in case of emergency? _____

Phone #: _____ Cell #: _____

Did your accident occur at work? ☐ Yes ☐ No Date and where did it happen: _____

Who is financially responsible for this bill? _____ I will be paying today by: ☐Cash ☐ Check ☐ Credit Card

I AM ULTIMATELY RESPONSIBLE FOR THIS BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION OF THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND AND AGREE THAT MY TREATMENT IS NOT GUARANTEE PAIN RELIEF. IT MIGHT TAKES SEVERAL TREATMENT.

_____ _____

PATIENT SIGNATURE DATE