



◆ **PATIENT INFORMATION FORM** ◆

**Ronald L. Teed, M.D., PC**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Male  Female  Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
If mailing address is the same as home address, check here:

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_

Patient referred to our clinic by: \_\_\_\_\_

Patient's preferred spoken language: \_\_\_\_\_

Patient's Marital Status: Single  Married  Divorced  Widowed  Other  \_\_\_\_\_

**Spouse/Guardian/Parent Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Spoken Language: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

**Emergency Contact Information** (Must have different phone than patient):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

◆ **INSURANCE INFORMATION:** ◆

- ◆ Are you being seen for a motor vehicle accident or work injury? Yes  No
- ◆ If patient is the policyholder to the insurance, check here:  (You do not need to complete the information below.)
- ◆ If insurance is through patient's spouse, parent, or if patient has a secondary policy please fill out insurance information below.

Primary Insurance Carrier: \_\_\_\_\_ Co-pay (if any): \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Policyholder's Date of Birth: \_\_\_\_\_

Policyholder's SSN: \_\_\_\_\_ Policyholder's Driver's License #: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ Co-pay (if any): \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Policyholder's Date of Birth: \_\_\_\_\_

Policyholder's SSN: \_\_\_\_\_ Policyholder's Driver's License #: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

◆ ◆ **DOES YOUR HEALTH PLAN REQUIRE A REFERRAL FOR SPECIALIST CARE?** ◆ ◆

Please make sure the referral has been completed prior to your appointment.

I hereby

- ◆ Authorize Cascade Orthopedic Surgery to release information to my insurance carrier(s) concerning my illness, injury, or treatment.
- ◆ Acknowledge that I am ultimately responsible for any prior authorization(s) or referral(s) required by my insurance.
- ◆ Assume complete financial responsibility for any and all costs denied, rejected, or pending by my insurance for extended periods of time.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_