Livonia Orthopedics & Sports Medicine, P.C.
PATIENT INFORMATION SHEET

Thank you for choosing our office for your orthopedic treatment. Please complete the following information as completely as possible.

Patient Name: _____ Female Male

Age: _____ Birthdate: _____ Marital Status: Single Married Widowed Divorced

Patient's Address: _____ City: _____ State: _____ Zip Code: _____

Patient's Social Security #: _____ Phone: _____ home _____ cell

Patient's Employer Name & Address: _____ Phone: _____

If child, name of Parent or Guardian: _____

Reason for seeing the doctor: _____ Date of Injury: _____

Is this a work related injury: Yes No Is there an open claim? Yes No Date of injury: _____

Is this an auto related accident: Yes No Is there an open claim? Yes No Date of injury: _____

Were you treated at an Emergency Room for this injury? Yes No If yes, where? _____

Insurance Information:

Subscriber's Name: _____ Relationship to patient: _____

Subscriber's Social Security # _____ Subscriber's Birthdate: _____

Subscriber's Employer: _____ Phone: _____

Secondary Insurance (if applicable):

Subscriber's Name: _____ Relationship to patient: _____

Subscriber's Social Security # _____ Subscriber's Birthdate: _____

Subscriber's Employer: _____ Phone: _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____ Secondary Phone: _____

I authorize use of this form on all of my insurance submissions.
I authorize release of information to all of my insurance carriers.
I understand that I am responsible for all bills incurred during my treatment.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage.

_____ _____

Patient/Parent/Guardian Signature **Date**