



Today's date: _____ E-mail: _____

First Name: _____ Middle: _____ Last: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Male Female

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Emergency Contact: _____ Phone: _____

Responsible Party: _____ Relationship to Patient: _____

Insurance: We will file your insurance; however, you will receive monthly statements. At each visit you will be responsible for paying co-pays, deductibles and balance due after insurance. You are responsible for promptly responding to all insurance inquiries.

Primary

Secondary

Insurance Company(1) _____

Insurance Company(2): _____

Phone#: _____

Phone#: _____

Policy#: _____

Policy#: _____

Group/Plan#: _____

Group/Plan#: _____

Policy Holder: _____

Policy Holder: _____

Policy Holder's: Date of Birth _____ Male Female

Policy Holder's: Date of Birth _____ Male Female

Policy Holder's SSN: _____

Policy Holder's SSN: _____

In consideration of the medical services rendered and/or to be rendered, I/we agree to pay OrthoNow, PLLC and/or its physician(s) the regular charge for said services. I/We further agree to pay any court costs and reasonable attorney's fees in the event that this account has to be referred to an attorney for collection. I/We understand that I/We are responsible for all charges

not paid by insurance. I/We certify that I/We have read the above or had it explained to me/us and agree to all of its terms and as evidence of this face sign my/our name below.

Patient Signature: _____