Account #

PATIENT INFORMATION

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

Age **Date of Birth**

SSN **Marital Status** ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Address **City** **State** **Zip Code**

Home Telephone **Work Telephone** **Cell Telephone**

Email **May we email you newsletters?** ◯ Yes ◯ No

Preferred Language **Ethnicity** ◯ Hispanic ◯ Non-Hispanic **Race**

PHYSICIANS / PHARMACY

Referring Physician *(First) (Last)* **Telephone**

Primary Care Physician *(First) (Last)* **Telephone**

Pharmacy Name **Telephone**

Address

GUARANTOR

☐ Guarantor Same As Patient **Relationship** **Telephone** **Date of Birth**

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

SSN **Occupation** **Employer**

Address **City** **State** **Zip Code**

PATIENT EMPLOYMENT AND EMERGENCY CONTACT

Employment Status ◯ Working ◯ Retired ◯ Disabled **Emergency Contact**

Occupation **Telephone** **Relationship**

Employer **Do You Have a Living Will or Advanced Directives?** ◯ Yes ◯ No

INSURANCE CARRIERS

	Carrier #1	Carrier #2
Name		
Policy/Claim #		
Group ID		
Policy Holder		
Policy Holder DOB		

Work Related? ◯ Yes ◯ No

Work Comp Insurance **Work Comp Contact**

Insurance Address **Contact Telephone**

Claim #

Insurance Telephone

I hereby authorize Fox Valley Orthopedics to release any information to my insurance company acquired in the course of my examination or treatment. I hereby authorize benefits to be paid directly to them. I authorize them to check pharmacies for my prescription history. I understand I am responsible for any unpaid balance.

Patient Signature *(Guardian if Patient is a minor)* Print Form **Date**

Patient Name_____

PLEASE SIGN & DATE:

I confirm that the privacy policy has been made available to me.

X_____Date:_____

Patient Signature (Guardian if Patient is a minor)

CONFIDENTIAL COMMUNICATION REQUEST

May we leave a message regarding medical information, please check your answer:

On answering machine at home?	☐ Yes	☐ No
With person at your home?	☐ Yes	☐ No
On your voicemail at work?	☐ Yes	☐ No
On your email account?	☐ Yes	☐ No
On your voicemail on your cell phone?	☐ Yes	☐ No

May we speak to a family member regarding your medical status? If so, with whom may we speak?

_____

X_____

Patient Signature (Guardian if Patient is a minor)

May we speak to a family member regarding your financial status? If so, with whom may we speak?

_____

X_____

Patient Signature (Guardian if Patient is a minor)

RELEASE OF LABORATORY & X-RAY INFORMATION

I hereby authorize Fox Valley Orthopedics to give lab, X-Ray, MRI, and CT results to a family member:

X_____

Patient Signature (Guardian if Patient is a minor)

ACKNOWLEDGEMENT REGARDING MEDICAL EQUIPMENT

Not all medical equipment may be paid for by my insurance company. We will let you know which items may not be covered. If my insurance carrier denies payment, I agree to be personally and fully responsible for payment.

X_____

Patient Signature (Guardian if Patient is a minor)

FOX VALLEY ORTHOPEDICS

fvortho.com

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2350 Royal Blvd.
Suite 200
Elgin, IL 60123
847.931.5300

ELGIN - RANDALL RD
1710 Randall Rd.
Suite 140
Elgin, IL 60123
224.293.1170

ELGIN - LIN LOR
1975 Lin Lor Ln.
Plaza Suite
Elgin, IL 60123
847.468.1400

BARRINGTON
420 W. Northwest Hwy
Suite M
Barrington, IL 60010
847.382.6766

GENEVA SOUTH
2525 Kaneville Rd.
Geneva, IL 60134
630.584.1400

GENEVA NORTH
2535 Soderquist Ct.
Geneva, IL 60134
630.584.1400

ALGONQUIN
2971 W. Algonquin Rd.
Suite 101A
Algonquin, IL 60102
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