



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 _____

Insurance Address _____

Work Comp Contact _____

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) _____

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

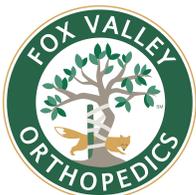
I hereby authorize Fox Valley Orthopedics to give lab, X-Ray, MRI, and CT results to a family member:

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)



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ELGIN - ROYAL BLVD
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
847.854.8590