

**ORTHOPAEDIC SPECIALTY CLINIC OF SPOKANE, PLLC**

785 E. Holland  
Spokane, WA 99218

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Primary Phone: (\_\_\_\_) \_\_\_\_\_ (home)  
Alternate Phone: (\_\_\_\_) \_\_\_\_\_ (cell)  
Alternate Phone: (\_\_\_\_) \_\_\_\_\_ (work)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F  
Age: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_  
Marital Status:  M  S  D  W  
How did you hear about us: \_\_\_\_\_  
(Examples: family doctor, another patient, emergency room, our staff, yellow pages, etc.)  
Family Physician: \_\_\_\_\_  
Family Physician Ph #: (\_\_\_\_) \_\_\_\_\_

**PATIENT EMPLOYMENT INFORMATION**

Employed  Retired  Unemployed  Other  
Employer's Name: \_\_\_\_\_  
Employer's Ph #: (\_\_\_\_) \_\_\_\_\_  
Occupation: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name	Phone
Relationship:	_____

**RESPONSIBLE PARTY:** (only if patient is under 18 years of age)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRIMARY INSURANCE**

Insurance Company Name: \_\_\_\_\_  
ID #: \_\_\_\_\_  
Group/Policy #: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Subscriber Soc Sec #: \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Company Name: \_\_\_\_\_  
ID #: \_\_\_\_\_  
Group/Policy #: \_\_\_\_\_  
Subscriber name: \_\_\_\_\_  
Subscriber Soc Sec #: \_\_\_\_\_

**AREA TO BE EXAMINED:** \_\_\_\_\_

Rt  Lt **Date of injury:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(if applicable)

**WORK or MOTOR VEHICLE RELATED INJURY** (Only applicable if injury is related to work or auto accident)

Claim Number: \_\_\_\_\_  
Insurance Carrier Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_

Date of injury: \_\_\_\_\_  
Claim Manager Name: \_\_\_\_\_  
Claim Manager Phone #: (\_\_\_\_) \_\_\_\_\_  
Employer at time of injury: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT** (please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I authorize Orthopaedic Specialty Clinic of Spokane to bill and collect payment(s) from my insurance carrier(s) and to release information necessary for the purpose of collection such payment(s). I authorize my insurance company to pay directly to Orthopaedic Specialty Clinic for their services. I understand it is my responsibility to contact my insurance carrier(s) if they do not respond to payment requests made on my behalf. I understand and agree that I am responsible for any amount not paid by my insurance with the exception of contractual agreements and other disallowed charges. I agree to inform Orthopaedic Specialty Clinic of Spokane regarding any changes in my personal billing information or my insurance billing information.

**Patient signature:** \_\_\_\_\_  
(parent or guardian to sign if patient is under 18)

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