OSC
Premier Bone and Joint Surgeons

Patient Information:

Name: _____ Date of Birth: ____/____/_____ Sex: ☐M ☐F

Address: _____ Age: _____ Social Security #: _____-_____-_____

_____ Marital Status: ☐ M ☐ S ☐ D ☐ W

City, State, Zip: _____ **How did you hear about us:**_____

Primary Phone: (_____)_____-_____ (Examples: doctor, another patient, emergency room, internet,

Alternate Phone: (_____)_____-_____ OSC staff, yellow pages, established patient, etc.)

Alternate Phone: (_____)_____-_____ Family Physician:_____

Email Address: _____ Family Physician Phone: (_____)_____-_____

Primary Language: ☐ English ☐ Spanish ☐ Russian ☐ Other:_____

Race: ☐White ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Hawaiian or Pac. Islander ☐Decline

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline

Patient Employment Information:

☐ Employed ☐ Retired ☐Unemployed ☐ Other

Employer's Name: _____

Employer's Phone: (_____)_____-_____

Occupation: _____

Emergency Contact Information:

Name: _____

Phone: (_____)_____-_____

Relationship: _____

Responsible Party: (Only fill out if patient is under 18 years of age.)

Name: _____ Relationship: _____

Address: _____ Home Phone: (_____)_____-_____

City, State, Zip: _____ Work Phone: (_____)_____-_____

Employer: _____ SSN: ____-___-_____ Date of Birth: ____/____/_____

Primary Insurance:

Insurance Company: _____

ID #: _____

Group/Policy #: _____

Subscriber Name: _____

Subscriber SSN: _____-_____-_____

Secondary Insurance:

Insurance Company: _____

ID #: _____

Group/Policy #: _____

Subscriber Name: _____

Subscriber SSN: _____-_____-_____

Work or Motor Vehicle Related Injury: (Only applicable if injury is related to work or auto accident)

Claim Number: _____ Date of Injury: ____/____/_____

Insurance Carrier Name: _____ Claim Manager Name: _____

Address: _____ Claim Manager Phone: (_____)_____-_____

City, State, Zip: _____ 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 (OSC) to bill and collect payment(s) from my insurance carrier(s) and to release information necessary for the purpose of collecting such payment(s). I authorize my insurance company to pay directly to OSC 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 OSC regarding any changes in my personal billing information or my insurance billing information.

Patient/Parent or Guardian Signature: _____ **Date:** _____/_____/_____