LANSING ORTHOPEDIC, PC
PATIENT INFORMATION

Name: ______________________________ Patient SS#: ______________
Last First Middle

Address: ______________________________ Birth Date: __________
Number Street City State Zip

Phone: ____________ Cell: ____________ Sex: ☐ Female ☐ Male

EMPLOYMENT INFO (If Applicable)

Patient's Occupation: ______________________________
Employer Name/Address/Phone: ______________________________

INSURANCE/POLICY HOLDER

Name of Primary Insurance: ______________________________
Name of Insured: ______________ SS#: ______________ Birth Date: __________

Name of Secondary Insurance (if applicable): ______________________________
Name of Insured: ______________ SS#: ______________ Birth Date: __________

RESPONSIBLE PERSON

Name: ______________ Birth Date: __________ Phone #: __________

PROBLEM/INJURY

Date of Injury: __________ Auto Related ☐ Work Related ☐ Other ______________
If Auto: did you contact your insurance agent? ☐ Yes ☐ No (Claim/File #______________)
If W/C: have you applied for Workers' Compensation? ☐ Yes ☐ No (Claim/File #______________)
Do you plan to apply for Worker's Compensation? ☐ Yes ☐ No
Are you currently working? ☐ Yes ☐ No Date you last worked? ______________
* If Auto or W/C we will need billing address: ______________________________

REFERRING or FAMILY DOCTOR

Name: ______________________________ Phone #: ______________
City: ______________

EMERGENCY CONTACT

Name: ______________________________ Relationship: ______________
Phone #: H) ______________ W) ______________ Cell) ______________

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Signature: ______________________________ Date: ______________