



# ORTHOPAEDIC CENTER OF ILLINOIS



## OFFICE USE ONLY

DOCTOR		ACCOUNT NUMBER			UPDATE/ NP /OPNP			
PATIENT'S NAME		SSN		MARITAL STATUS			DATE OF BIRTH	AGE
				S	M	W	D	SEP
STREET ADDRESS		CITY AND STATE			ZIP CODE		HOME PHONE	
PATIENT'S EMPLOYER		OCCUPATION			BUSINESS PHONE/EXT			
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP CODE			
SPOUSE OR LEGAL GUARDIAN		SOCIAL SECURITY NUMBER			DATE OF BIRTH			
SPOUSE OR LEGAL GUARDIAN EMPLOYER		OCCUPATION			BUSINESS PHONE/EXT			
EMPLOYER'S ADDRESS		CITY AND STATE			ZIP CODE			
NEXT OF KIN (OTHER THAN SPOUSE)				RELATIONSHIP		HOME PHONE		
NEXT OF KIN ADDRESS				CITY AND STATE		ZIP CODE		

## INSURANCE INFORMATION

MEDICARE NUMBER		MEDICAID NUMBER		
Primary Insurance Company		Primary Insurance Company Address		
Name of the Policy Holder		Social Security Number	Date of Birth	Policy Number
Secondary Insurance Company		Secondary Insurance Company Address		
Name of the Policy Holder		Social Security Number	Date of Birth	Policy Number
Insurance Co. for Workers Comp. or Liability		Workers Comp. or Liability Insurance Co. Address		
Contact Person for Workers Comp. or Liability		Phone Number of Contact		Claim Number

## DOCTORS INFORMATION

REFERRING DOCTOR	FAMILY DOCTOR
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I realize that my insurance coverage is a contract between myself and the insurance company and that not all services are covered benefits in all health plans. I am ultimately responsible for any unpaid balance on my account for any professional services rendered. I understand any reduction of payment or denial of payment by my insurance company due to "usual and customary rates" is my responsibility to pay. I hereby assign to the above named physician the medical benefits to which my dependents or I are entitled. I authorize the release of any medical or other information necessary to process this claim and/or to collect this debt. I hereby agree to pay a finance charge at the rate of 1 1/2 % per month (18% per year) on all unpaid balances commencing 60 days from the date of service. In addition, I agree to pay any additional charges to collect my unpaid bills, including but not limited to, reasonable attorney fees, and court costs and collection agency fees. I agree to pay a \$20 service charge on all return checks. By signing below, I do affirm that I have read all the above information and have answered all questions truly and to the best of my ability. I also affirm that I understand the contents of this document.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of responsible party if other than patient

\_\_\_\_\_  
Date