Date:
Location:
Provider:

SAH ORTHOPAEDIC ASSOCIATES
INSTITUTE FOR JOINT RESTORATION

Please Print

Patient Name _____ Sex: **M** **F**
First MI Last

Date of Birth ___/___/___ Age _____ Social Security # _____

Marital Status M W D S Driver License # _____

Cell Phone ( ) _____ Home Phone ( ) _____

Email Address _____

Address _____ Emergency Contact Name _____

City _____ State _____ Zip _____ Emergency Phone ( ) _____

Employer _____ Employer Phone ( ) _____

Occupation _____ Currently working Yes / No

Race/Ethnicity: _____ Religious Preference: None or _____

Preferred Language Spoken: _____

Referring Doctor _____
First Name Last Name Address

REQUIRED TO BILL INSURANCE

Primary Insurance _____ ID: _____

Subscriber's Name _____ Subscriber's D.O.B _____

Group or Local _____ Date of Injury _____

Secondary Insurance _____ ID: _____

Subscriber's Name _____ Subscriber D.O.B _____

Group or Local _____ Date of Injury _____

Your signature authorizes Sah Orthopaedic Associates to furnish the above-mentioned insurance company (ies) all information they may request. I hereby assign to Sah Orthopaedics all basic and major medical expense relative to the services rendered. It is understood that any money received from the above named insurance companies, over and above my indebtedness, will be refunded to me when my bill is paid in full. Payment in full is requested of any unpaid balance over 45 days. I also understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Sah Orthopaedic Associates can only bill my insurance provided I supply accurate and current information. I agree to respond in a timely manner to any request from my insurance for any illness/accident/injury information they may request directly from me. Failure to do will make me liable for the debt to Sah Orthopaedic Associates. All supplies that I may receive will also be my financial responsibility and payable when received. Medicare patients are responsible for supplies after Medicare is billed.

Patient Signature _____ **Date** _____