

- How did you hear about us?
- Friend
 - Radio
 - Yellow Pages
 - Newspaper
 - Other _____



Twin Falls Orthopedic, P.L.L.C.
Orthopedic & Fracture Surgery (208) 734-3455
 562 Shoup Ave. West • Twin Falls, Idaho 83301



John W. Howar, M.D.
 Frederick L. Surbaugh, M.D.
 R. Tyler McKee, D.O.
 Randal Wraalstad, D.P.M.
 Anna Hawker, F.N.P.

Thank you for taking time to complete this form. This information is necessary for the preparation of your records.
 You are responsible to Twin Falls Orthopedic, P.L.L.C. for all charges as billed. As a courtesy, we will file your insurance. However, your contract is with your insurance company. They are responsible to make payments directly to you, or to Twin Falls Orthopedic, P.L.L.C. if you assign benefits to us. If extended terms are desired on large balances, our credit manager will be happy to discuss a payment schedule most convenient for you.

1 PATIENT PERSONAL INFORMATION

Prfrd <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> <input type="checkbox"/> Dr <input type="checkbox"/> Ms <input type="checkbox"/> Miss		First Name	Middle Name	Last Name	Employer or School
Home Address			Work/School Address		
City		State	Zip Code	Cell Phone	City
Home Phone ()		Age	Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Work Phone ()
Driver's License Number		Expires	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Referring Physician	Employed by employee for: <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years
Social Security Number		Occupation <input type="checkbox"/> Student <input type="checkbox"/> Retired	-If retired, list previous occupation	First Name	Last Name
				UPIN	Staff Entry
				City	Phone ()
				Date Last Seen	/ /

2 SPOUSE/FIRST PARENT INFORMATION SECOND PARENT/GUARDIAN INFORMATION

Prfrd <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> <input type="checkbox"/> Dr <input type="checkbox"/> Ms <input type="checkbox"/> Miss		First Name	Middle Name	Last Name	Prfrd <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> <input type="checkbox"/> Dr <input type="checkbox"/> Ms <input type="checkbox"/> Miss	First Name	Middle Name	Last Name	
Home Address				Home Address					
City			State	Zip Code	City			State	Zip Code
Home Phone ()			Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone ()			Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Work Phone ()			Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other		Work Phone ()			Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other	
Social Security Number			Drivers License Number	Expires	Social Security Number			Drivers License Number	Expires
Employer School			Employed by employee for: <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years		Employer School			Employed by employee for: <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years	
Work/School Address				Work/School Address					
City			State	Zip Code	City			State	Zip Code
Employer Phone ()			Occupation <input type="checkbox"/> Student <input type="checkbox"/> Retired		Employer Phone ()			Occupation <input type="checkbox"/> Student <input type="checkbox"/> Retired	

3 INSURANCE - Please present your insurance forms, cards and identification to the receptionist

Patient First Name	Middle/Maiden	Last Name	Birth Date / /	Age	SS#
Primary Carrier Name <input type="checkbox"/> Medicare			Secondary Carrier Name <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid		
Claims Address			Claims Address		
City		State	Zip Code	City	
Phone ()		Authz. ()		Phone ()	
Employer or Group Name		Group Number		Employer or Group Name	
Insured Name on I.D. Card		Birth Date / /		Insured Name on I.D. Card	
Member Policy ID or Social Security Number		Patient relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Member Policy ID or Social Security Number	
				Patient relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

4 ACCIDENT INFORMATION

Date of Accident: _____

Place of Accident: _____

Brief Description of Accident:

Today I will pay my bill:
 Cash Check No. _____ Visa Mastercard

Credit Card # _____ Exp. Date _____

Signature _____

4 AUTHORIZATION

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED ATTACHED.

SIGNED (INSURED OR AUTHORIZED PERSON)

I hereby authorize Twin Falls Orthopedic, P.L.L.C. to release all financial, medical and other information to _____ insurance company or my representative, including my attorney of record, with respect to all illnesses or accidents, and medical histories. This information may be in photocopy form. A photocopy of this authorization shall be considered as valid as the original to be used on all insurance claims (including Medicare). I declare that the above answers and statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge receipt of a copy of this form with full disclosure.

SIGNED (INSURED OR AUTHORIZED PERSON)
