Patient's Name: _____ Sex: _____
Last First Middle

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Marital Status: Single___Married___Widow____ Social Security: _____

Employer: _____ Language Preference:_____ Race:_____

Email Address: _____

Spouse's Name: _____Birthdate: _____ Phone: _____ Age: _____

Spouse's Employer: _____Work Phone: _____Social Security: _____

Father's Name _____Birthdate:_____Phone:_____Age:_____
(If patient is a minor)

Father's Employer:_____Work Phone:_____Social Security:_____

Mother's Name _____Birthdate:_____Phone:_____Age:_____
(If patient is a minor)

Mothers's Employer:_____Work Phone:_____Social Security:_____

Person Responsible for Payment:_____

Nearest friend or relative not living with you:_____Phone:_____

Date of Injury:_____Is injury: Work related:_____Auto Accident:_____Other:_____

Area of body injured:_____Right:_____Left:_____

We are happy to bill your insurance as a courtesy to you, however; it is the patient's and/or legal guardian's responsibility to ensure payment for all medical services rendered. Please provide a copy of your card.

PRIMARY INSURANCE INFORMATION
Company Name_____Subscriber ID#_____Group #_____
Policy Holder_____Birthdate_____
Insured Address_____

SECONDARY INSURANCE INFORMATION
Company Name_____Subscriber ID#_____Group #_____
Policy Holder_____Birthdate_____
Insured Address_____

I accept the responsibility for payment to Casey I. Huntsman, M.D., Jason G. Dalling, M.D., and/or Brandon Mennear, M.D. for any portion of the account that the insurance carrier does not pay. In the event that I do not have health insurance, I agree to accept responsibility for payment of my account with a payment applied to the account each month. All balances over 120 days will be assessed an interest rate of 1% per month (12% A.P.R.).

I authorize Casey I. Huntsman, M.D., Jason G. Dalling, M.D., and/or Brandon Mennear, M.D. to release any information regarding my medical care to the insurance carriers. I authorize any medical care facility to provide all information on my medical history to Casey I. Huntsman, M.D., Jason G. Dalling, M.D., and/or Brandon Mennear, M.D. I assign to Huntsman Orthopaedic Surgery and Sports Medicine, P.A., Dallco Orthopaedics & Sports Medicine PLLC, and/or Biddulph and Huntsman Orthopedics, PLLC all benefits of surgical and medical care, payable under the above policy.

Date:_____Responsible Party:_____