BEAUMONT BONE AND JOINT INSTITUTE

PATIENT NAME LAST FIRST MIDDLE INITIAL				HOME PHONE
SEX (CIRCLE ONE) *M* *F*	AGE	BIRTHDATE / D.O.B.	CELL PHONE #	PATIENT SOCIAL SECURITY NUMBER
PATIENT MAILING ADDRESS				WORK PHONE
CITY STATE ZIP				EMPLOYER OF POLICY HOLDER
RESPONSIBLE PARTY NAME AND ADDRESS *(If different)*				POLICY HOLDER DATE OF BIRTH

POLICY HOLDER NAME		RELATIONSHIP TO PATIENT	S.S.# POLICY HOLDER
NAME OF INSURANCE COMPANY OR MEDICARE/MEDICAID		POLICY NUMBER	GROUP NUMBER
SECOND POLICY - HOLDER NAME	D.O.B.	RELATIONSHIP TO PATIENT	S.S.# POLICY HOLDER
NAME OF INSURANCE COMPANY		POLICY NUMBER	GROUP NUMBER
SECOND POLICY/HOLDER EMPLOYER			
THIRD POLICY - HOLDER NAME	D.O.B.	RELATIONSHIP TO PATIENT	S.S.# POLICY HOLDER
NAME OF INSURANCE COMPANY		POLICY NUMBER	GROUP NUMBER
REASON FOR VISIT (what part(s) of body)?			
FAMILY DOCTOR OR PCP *(If applicable)*		ACCIDENT? *(circle one)* *Y* *N*	DATE OF ACCIDENT

I hereby authorize my insurance benefits to be paid to me or directly to Beaumont Bone and Joint Institute, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

If I am a Medicare recipient, I understand there may be charges incurred by me for services rendered which may not consider for payment. With this understanding, I agree to assume responsibility for the charges which Medicare does not consider.

SIGNATURE:_____ **DATE:**_____