Patient's Name: ____ Sex: ________
Last First Middle

Home Address: ____________________ City: ______________ State: _____ Zip: ________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Birthdate: ________ Age: ______ Marital Status: Single___Married___Widow____ Social Security: ____________

Employer: ________________________________ Language Preference:________ Race:________

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 aud/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 Gregory E. Biddulph, M.D., Casey I. Huntsman, M.D. and/or Jason G. Dalling, 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 Gregory E. Biddulph, M.D., Casey I. Huntsman, M.D and/or Jason G. Dalling, 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 Gregory E. Biddulph, M.D., Casey I. Huntsman, M.D and/or Jason G. Dalling, M.D.

I assign to Gregory E. Biddulph Orthopedics, PC, Huntsman Orthopaedic Surgery and Sports Medicine, P.A. and/or Biddulph and Huntsman Orthopedics, PLLC all benefits of surgical and medical care, payable under the above policy.

Date:______________Responsible Party:____