

CASEY I. HUNTSMAN, M.D. – HUNTSMAN ORTHOPAEDIC SURGERY AND SPORTS MEDICINE PA  
JASON G. DALLING, M.D. – DALLCO ORTHOPAEDICS & SPORTS MEDICINE, PLLC  
BRANDON MENNEAR, M.D. – HUNTSMAN & DALLING ORTHOPEDICS, PLLC

3300 Washington Parkway  
Idaho Falls, ID 83404

Phone: 208-522-6662

Fax: 208-522-0880

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)

Mother'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 Huntsman & Dalling Orthopedics, PLLC all benefits of surgical and medical care, payable under the above policy.

Date: \_\_\_\_\_ Responsible Party: \_\_\_\_\_