Name:
DOB:
Chart:
Age:
Date:

Orthopaedic and Sports Clinic
1014 W. St. Clare Blvd, Suite 1020
Gonzales, LA 70737

Scott G. Petrie, M.D.
Robert N. Moukarzel, M.D.
David H. Sepulveda, PA-C

For office use only:

Account # _____ Referring Physician: _____

Insurance: Primary _____ Secondary _____

Workers Comp# _____ Attorney: _____

Patients Name (First) _____ (Last) _____ (Maiden) _____

Address _____ City _____ State _____ Zip _____

Patients Phone (Home) _____ (Work) _____ (ext) _____ (Cell) _____

Sex _____ Birthdate _____ Age _____ Marital Status ____M ____S ____D ____W

Patient SS # _____ Employer _____ Occupation _____

Spouses Name _____ Employment _____ SS# _____

Emergency Contact(Name) _____ Relationship _____ Phone# _____

Does the patient have a living will? _____ Yes _____ No How were you referred to us? _____

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Insurance information:

PRIMARY Insurance _____	**SECONDARY** Insurance _____
Policy Holder Name _____	Policy Holder Name _____
Policy Holder SS# _____	Policy Holder SS# _____
Policy Holder DOB _____	Policy Holder DOB _____
Copay Amount _____	Copay Amount _____

Is your visit a result of an accident? (type): ☐ Auto ☐ Work Related ☐ Other Date of Accident _____ City/State _____

Have you retained an Attorney? ☐ Yes ☐ No Attorney Name _____ Phone # _____

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Responsible Party Information: ☐ **Same as patient**

Person Responsible for Bill _____ Date of Birth _____

Address _____ City/State/Zip _____

Relationship to Patient _____ Soc.Sec.# of responsible party _____

Phone Number(Home) _____ (Work) _____ (ext) _____ (Cell) _____

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I hereby assign my insurance benefits under my plan for medical services rendered to The Orthopaedic and Sports Clinic, 1014 W. St. Clare Blvd., Suite 1020, Gonzales, LA 70737. I understand that I am financially responsible for any charges not covered by my insurance. I also hereby authorize the release of information required in the course of my examination as may be needed to process my claims. By signing below I have read and understand this statement and I acknowledge that the information provided is true and accurate.

Patient Signature _____ Date _____

(If patient is a minor)
Signature of responsible party _____ Date _____

Our Policy requires payment as services are rendered whether it's a copay, deductible or coinsurance