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: ____ Sex: ____

Spouse's Employer: ______________________ Work Phone: __________ Social Security: __________

Father's Name: ______________________ Birthdate: __________ Phone: __________ Age: ____ Sex: ____
(If patient is a minor)

Father's Employer: ______________________ Work Phone: __________ Social Security: __________

Mother's Name: ______________________ Birthdate: __________ Phone: __________ Age: ____ Sex: ____
(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 insure payment for all medical services rendered. Please provide a copy of your card.**

**PRIMARY INSURANCE INFORMATION:**
Company Name ______________________ Subscriber ID# __________ Group # __________
Policy Holder ______________________ Birthday __________
Insured Address ________________________________________

**SECONDARY INSURANCE INFORMATION:**
Company Name ______________________ Subscriber ID# __________ Group # __________
Policy Holder ______________________ Birthday __________
Insured Address ________________________________________

I accept the responsibility for payment to Gregory E. Biddulph, M.D. and /or Casey I. Huntsman, 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. and /or Casey I. Huntsman, 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. and /or Casey I. Huntsman, M.D.

I assign to Biddulph and/or Huntsman Orthapaedics, P.A. all benefits of surgical and medical care, payable under the above policy.

<u>Ownership Disclosure</u>: Please note that the physicians of Biddulph and Huntsman Orthopedics have individual ownership interests in Mountain View Hospital and that they may refer you for services at Mountain View Hospital. If you would prefer to receive care or testing at another hospital of facility, please discuss this with your treating physician so that he or she may determine if that is possible.

Date: ____________________ ResponsibleParty: ______________________________

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