Southwest Bone and Joint Institute
1268 E. 32nd Street
Silver City, NM 88061
Office (575) 534-1919 Fax (575) 534-0135

Patient Information Record

Today's Date: _____

Patient Name: _____

Mailing Address: _____

Physical Address: _____

Social Security Number: _____-_____-_____

Birthdate: _____/_____/_____ **Gender:** ☐ Male ☐ Female

Home Phone Number: _____

Work Phone Number: _____**Cell Phone Number:** _____

Patient Email: _____ **PCP:** _____

Emergency Contact Person: _____

Relationship: _____ **Emergency Phone Number:** _____

Marital Status: Married ☐ Single ☐ Other ☐

Primary Insurance Name: _____

Policy Number: _____

Group Number: _____

<u>Secondary Coverage</u>

Secondary Insurance Name: _____

Secondary Insurance Policy Number: _____

Group Number: _____

Insured Name: _____

PLEASE PRESENT YOUR INSURANCE CARD AND A PICTURE ID AT THE FRONT DESK

Race: American Indian ☐ Black or African American ☐ White ☐ Other Race ☐
Preferred Language: English ☐ Spanish ☐ Other ☐
Ethnicity: Black ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐

Local Pharmacy: _____

Employer: _____

Employer Address: _____
_____

Employer Phone: _____ **Email:** _____

SPOUSE INFORMATION

Name: _____ **SSN:** _____-_____-_____ **DOB:** _____

Employer: _____ **Work Phone:** _____

GUARDIAN/PARENT INFORMATION IF PATIENT IS A MINOR

MOTHER
Name: _____ **DOB:** _____
SSN: _____-_____-_____
Employer: _____

FATHER
Name: _____**DOB:** _____
SSN: _____-_____-_____
Employer: _____

Address: (If Different from Above) _____

Home Phone: _____ **Work Phone:** _____

CHECK-OUT NOTE

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our patient relations dept. prior to SURGERIES. I understand that if I miss two consecutive therapy appointments, I may be removed from the therapy schedule.

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS DECLARATION

I herby authorize release of any medical information necessary to process my insurance claims. Furthermore, I irrevocably ASSIGN to SOUTHWEST BONE AND JOINT INST. and/or it's DOCTORS any and all payments from my insurance(s) for services rendered. I understand and agree to the above conditions. This authorization can only be revoked in writing. A copy of the authorization shall be as valid as the original.

FINANCIAL RESPONSIBLE PARTY

I/we, _____,(Patient/Parent/Guardian) agree to be financially responsible for any and all medical bills and/or costs not paid by insurance, Medicare and/or Medicaid for _____(patient). I shall immediately inform and provide the necessary information to Southwest Bone and Joint Institute, P.C. of any and all changes in my insurance, Medicare and/or Medicaid policies. I understand this is a Contract and I agree that if Southwest Bone and Joint Institute, P.C. has to proceed with collections of monies owed on this account, then I/we will be liable for Southwest Bone and Joint Institute, P.C. attorney's fees and costs.

Signature: _____ **Date:** _____