Southwest Bone and Joint Institute

1268 E. 32nd St
Silver City, NM 88061
(575) 534-1919

Patient Information Record

Today's Date:

Please indicate who we are billing for this visit:

Worker's Comp: _______ (initial) OR Personal Insurance: ______ (initial)

Patient Name:
Mailing Address:

Physical Address:____

Social Security Number: ______-______-________

Birthdate: **Gender:**

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: ____

Secondary Coverage

Secondary Insurance Name: ____

Secondary Insurance Policy Number: ______________________________________

Group Number: ____

Responsible Party Name: ____

Date of Birth: ______________________ **Phone:** ______________________________

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 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 its 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:**