

GRAND HAVEN BONE & JOINT **PATIENT INFORMATION SHEET**

Patient's Name: _____ Social Security Number: _____-_____-_____
Address: _____ Home Phone: (____)____-_____
City/State/Zip: _____ Work Phone: (____)____-_____
Date of Birth: ___/___/____ Age: _____ Sex: M F Cell Phone: (____)____-_____
Email address: _____
Occupation: _____ Employer: _____
Address: _____
Emergency Contact: _____
Relationship: _____ Phone: (____)____-_____

COMPLETE IF PATIENT IS A MINOR OR IS COVERED BY PARENT'S INSURANCE:

Father's Name: _____	Mother's Name: _____
Address: _____	Address: _____
Home Phone: (____)____-_____	Home Phone: (____)____-_____
<i>I consent to allow the physicians and staff of Grand Haven Bone & Joint to treat my minor child.</i>	
_____ Parent or guardian signature if patient is a minor	_____ Date

INSURANCE INFORMATION: (Please fill out if you do not have your insurance card with you or patient is not primary cardholder.)

Primary Insurance Carrier: _____ Policy Number: _____
Subscriber's Name: _____ SS# _____-_____-_____
DOB ___/___/_____
Secondary Insurance Carrier: _____ Policy Number: _____
Subscriber's Name: _____ SS# _____-_____-_____
DOB ___/___/_____

WORK HISTORY (For Worker's Compensation Patients only)

Employer's Name: _____ Phone: (____)____-_____
Send Claim Information to:
Contact Person: _____ Phone: (____)____-_____
Address: _____ City/State/Zip: _____
Date of Injury: _____ Claim Number: _____
Are you currently working? Yes ___ No ___ Regular job? Yes ___ No ___
Is there a legal case pending regarding this injury? Yes ___ No ___

I hereby authorize Dirk Bakker, M.D. and/or Rick Baszler, D.O. of Grand Haven Bone & Joint and/or representatives to release medical information including my diagnosis, medical history, and other material contained within those records to referring physicians, hospitals, laboratories, therapists, and employer(s), as deemed necessary. I also authorize the release of information necessary for processing my insurance, liability, Worker's Compensation or litigation claims. I authorize payment of benefits, where applicable, directly to those physicians otherwise payable to me for their services. I understand that I am financially responsible for any co-insurance, deductibles, co-pays, and non-covered benefits.

Patient Signature: _____ **Date:** _____

