Crystal Lake Orthopaedic Surgery
And Sports Medicine, LTD
750-C E. Terra Cotta Ave
Crystal Lake, IL 60014

Acct# ____________
X-ray#____________

PATIENT INFORMATION

Legal Name (Last, First, M.I.) ____Sex: M F

Date of Birth _________________ Age: ______ Social Security # ______________________

Home Address ______________________________ City/State/Zip ________________________

Home Telephone_____________________________Cell Telephone _______________________

Employer_____________________________ Occupation ___________________________

Employer Address/City/State/Zip____

Employer Telephone____________________ School Attending ___________________________

Who Referred You: ____

Martial Status: M S D Spouse Name: _____________________________________

May we give information to your spouse/parent: Yes No Parents Name:__________________

MEDICAL INFORMATION:

Medical Physician's Name ______________________ Did this physician refer you? Y N

City/State/Zip ____

Medication Allergies ____

INSURED PARTY INFORMATION

Please complete the information below if someone other than the patient holds the health insurance plan.

Legal Name _________________________ Social Security#________________Birth Date _________

Relationship to patient _________________ Telephone ___________________________________

Address/City/State/Zip (if different than patient) ____

Employer ___________________________ Employer Telephone __________________________

Employer Address/City/State/Zip ____

I understand that, under the Health Insurance Portability & Accountability Act of 1996. I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to – conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers, and conduct normal healthcare operations such as quality assessments and physician certifications. I understand that Crystal Lake Orthopaedic Surgery & Sports Medicine, LTD reserves the right to modify the privacy practices outlined in the notice. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I also have read the Financial Policy provided by Crystal Lake Orthopaedic Surgery & Sports Medicine, LTD and understand and accept the policy. I also have been provided with the financial statement and understand that it is the patient's responsibility to address any outstanding claims on my account.

Date: ________________ Signature ____

Relationship to Patient ____

FOR OFFICE USE ONLY

Todays Date ___________ Work Comp: Yes No Pre Cert: Yes No Pre Cert#: _____________ Deductible: ___________ Effective Date:_________ Out of pocket/coinsurance _______________________ Name of Insurance Rep: _______________________ Comments______________ _______________________	Todays Date ___________ Work Comp: Yes No Pre Cert: Yes No Pre Cert#: _____________ Deductible: ___________ Effective Date:_________ Out of pocket/coinsurance _______________________ Name of Insurance Rep: _______________________ Comments______________ _______________________	Todays Date ___________ Work Comp: Yes No Pre Cert: Yes No Pre Cert#: _____________ Deductible: ___________ Effective Date:_________ Out of pocket/coinsurance _______________________ Name of Insurance Rep: _______________________ Comments______________ _______________________