Bay Area Orthopaedics & Sports Medicine

Patient Billing Information Data Sheet

Please Print Clearly – This Information is Essential to Accurate Information In our Computer

Date: ____________________ Circle: Work Comp / Auto Accident / Other

Last Name: ________________________________ First Name: ____________________ MI: ______

Address: ________________________________ DOB: ________________ ❑ Male ❑ Female

City/State/Zip: ________________________________ Marital Status: ______ SS# ____________________

Home Phone: ________________________________ Work Phone: ____________________

Employment Status: ❑ Employed ❑ FT Student ❑ PT Student ❑ Retired ❑ None Diabetic: ❑ Yes ❑ No

Referring Physician: ________________________________ Phone: ________________ Fax: ________________

PCP (If different): ________________________________ Phone: ________________ Fax: ________________

Primary Insurer: ________________________________ Secondary Insurer: ____________________

HMO ( ) or PPO ( ) Filing Address: ____________________

Filing Address: ________________________________ ____________________

________________________________ Phone (Auth/Pre-Cert): ____________________

Phone (Auth/Pre-Cert): ________________________________ Policy No.: ____________________

Policy No.: ________________________________ Claim No. (if WC or other accident): ____________________

Group No.: ________________________________ Group No.: ____________________

Card Holder's Name: ________________________________ For WC or Auto.: Date of Injury ____________________

Primary Insured's DOB: ________________________________ Name of Adjustor: ____________________

Primary Insured's SSN#: ________________________________ Effective Date: ____________________

Deductible ____________ Met? ❑ Y ❑ N Co-Pay ______ Deductible ____________ Met? ❑ Y ❑ N Co-Pay ______

Describe Problem, Injury or reason for seeing the Doctor: ________________________________

Date when Problem or Injury occurred? ________________________________

Referred to our office by? ________________________________

Please read & sign authorization, that follows: I hereby authorize release of any information necessary for completion of insurance claims and direct payment to Bay Are Orthopaedics & Sports Medicine. I understand I am financially responsible for all charges not covered by Medical Insurance including collection agency fees, court costs and/or attorney fees necessitated by any collection activity caused by my failure to clear any balance due.

Signature of Patient (or Parent): ________________________________ Date: ____________