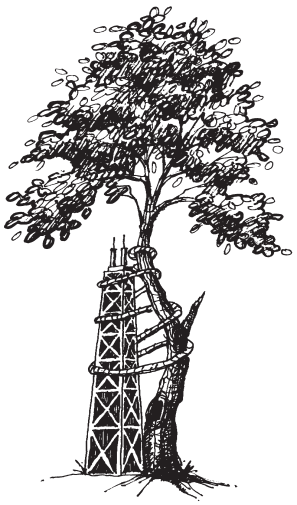

WINDY CITY ORTHOPEDICS & SPORTS MEDICINE

2617 W. PETERSON AVE. CHICAGO, ILLINOIS 60659

Toll Free 877-549-4490 Suburban 847-475-0200 Chicago 773-743-1981

www.Jockdoc.net

TODAY'S DATE _____/_____/_____

WHO REFERRED YOU TO THE OFFICE? (Please Circle)

Internet Family Friend Yellow Pages Previous Patient

Swedish Covenant Hospital PPO Book Loyola Res Info St.Francis ER

Swedish Covenant ER Occupational Health Other _____

Referring Dr./Primary Care Physician _____

PATIENT NAME_____

FIRST MIDDLE LAST

ADDRESS _____

NUMBER STREET CITY STATE ZIP

E-Mail _____@ _____ MARITAL STATUS: Single Married Divorced Widowed

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Birthdate_____/_____/_____ AGE_____ SEX: (PLEASE CIRCLE) Male Female

Social Security # (REQUIRED) _____-_____-_____ DRIVER'S LIC.#_____

RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT: (PLEASE CIRCLE) SELF SPOUSE CHILD OTHER

PATIENT'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

NUMBER STREET CITY STATE ZIP

GUARANTOR INFORMATION PERSON RESPONSIBLE FOR THE BILL IF OTHER THAN THE PATIENT

GUARANTOR'S NAME_____

FIRST MIDDLE LAST

ADDRESS_____

NUMBER STREET CITY STATE ZIP

SS# **(REQUIRED)** _____-_____-_____ DRIVER'S LIC.#_____ DATE OF BIRTH _____/_____/_____

RELATIONSHIP TO PATIENT _____

GUARANTOR'S EMPLOYER _____ WORK PHONE (_____)_____

EMPLOYER'S ADDRESS _____

NUMBER STREET CITY STATE ZIP

SUBSCRIBER INFORMATION PERSON RESPONSIBLE FOR INSURANCE COVERAGE

SUBSCRIBER'S NAME_____

SUBSCRIBER'S SS # **(REQUIRED** _____-_____-_____ SUBSCRIBER'S DATE OF BIRTH _____/_____/_____

RELATIONSHIP TO PATIENT _____ PHONE (_____)_____

SUBSCRIBER'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

NUMBER STREET CITY STATE ZIP

PLEASE CONTINUE ON THE BACK

EMERGENCY CONTACT INFORMATION

THE PRACTICE OF ORTHOPEDIC SURGERY IS FREQUENTLY SUBJECT TO EMERGENCIES. ALTHOUGH WE TRY TO MAINTAIN OUR OFFICE SCHEDULE, UNFORTUNATELY THERE ARE TIMES WHEN WE MUST DISCUSS TREATMENT, RE-SCHEDULE APPOINTMENTS OR RELAY MESSAGES. DUE TO THE HIPAA PRIVACY REGULATIONS REGARDING THE RE-LEASE OF PRIVILEGED MEDICAL INFORMATION, IT IS VERY IMPORTANT THAT WE HAVE YOUR PERMISSION TO LEAVE A MESSAGE AT A PHONE NUMBER, THROUGH E-MAIL OR THROUGH ONE OF YOUR RELATIVES OR FRIENDS.

E-MAIL _____@_____

DAYTIME PHONE NUMBER FOR EMERGENCIES (_____)_____

NAME _____ RELATIONSHIP_____ PHONE (_____)_____

ADDRESS _____

NAME_____ RELATIONSHIP_____ PHONE (_____)_____

ADDRESS _____

NAME_____ RELATIONSHIP_____ PHONE (_____)_____

ADDRESS _____

X SIGNATURE _____ DATE _____/_____/_____

By signing this form, I hereby authorize Dr. G. Klaud Miller and his staff to perform a consultation and to conduct an examination with diagnostic testing, if needed, to completely assess my medical condition.

X SIGNATURE _____ DATE _____/_____/_____

FILL OUT ONLY IF YOU ARE CLAIMING AN INDUSTRIAL, LEGAL OR WORKMAN'S COMPENSATION CLAIM

DATE OF INJURY _____/_____/_____ TIME OF INJURY : _____ AM _____PM

NAME OF EMPLOYER WHEN INJURED_____

ADDRESS _____ PHONE # (_____)_____

PERSON TO CONTACT_____ OCCUPATION WHEN INJURED_____

iN THE EVENT MY EMPLOYER DOES NOT AUTHORIZE WORKMEN'S COMPENSATION BENEFITS FOR MY INJURY, I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY WINDY CITY ORTHOPEDICS AND SPORTS MEDICINE.

X SIGNATURE _____ DATE _____/_____/_____

DO YOU HAVE AN ATTORNEY REPRESENTING YOU FOR THIS INJURY? (PLEASE CIRCLE) YES NO

ATTORNEY'S NAME _____ PHONE (_____)_____

ADDRESS _____