The Idaho Clinic
HIP AND KNEE REPLACEMENT

Today's Date: _____

PATIENT DEMOGRAPHIC INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Gender: ☐ Female ☐ Male ☐Married ☐Single ☐Divorced ☐Widowed ☐Other

Race: ☐African-American ☐Native American ☐Asian ☐Caucasian ☐Hispanic ☐Other: _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other: _____

Preferred Language: ☐English ☐ Spanish ☐Other: _____ ☐Translator Needed

Home Address: _____

City, State, Zip: _____

Home #: _____ Work #: _____ Cell #: _____

E-mail: _____

How did you hear about us?

☐ Google ☐ PCP ☐ Insurance Network ☐ Family or Friends ☐ Other: _____

Mark all that apply:

☐ You have my permission to leave information on my answering machine/voicemail regarding my medical care, test results, and appointment information.

☐ Only release information to me personally.

☐ You have my permission to discuss my medical care and release medical records with the individuals listed below as well as my Emergency Contact:

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____

PRIMARY CARE PROVIDER (PCP)

Provider Name: _____ Phone #: _____

Address: _____

CONTINUED ON THE BACK….

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

Phone Number: _____

INSURANCE INFORMATION

Health Insurance Company: _____

Insurance ID #: _____

Policy/Group #: _____ Plan Name (if applicable): _____

Name of Primary Subscriber: _____ Subscriber DOB: _____

INSURANCE & PAYMENT POLICY

I authorize The Idaho Clinic: Hip & Knee Replacement to bill my medical insurance for services provided and request that all payments be made directly to the clinic. I understand that the clinic's relationship is with me as the patient, not with my insurance company. I acknowledge that I am responsible for any co-payments, deductibles, or charges not covered or denied by my insurance. We respectfully request that all professional services be paid for at the time they are rendered.

_____

Signature of Patient/Responsible Party

_____

Relationship to Patient (if applicable)