Welcome to the office of Bright McConnell, III, MD

ALL BLANKS MUST BE FILLED IN FOR OUR RECORDS.

Today's Date: _____/_____/_______

Patient's Name: ____

PATIENT INFORMATION RECORD

Brief description of reason for today's visit: ____

Street Address: ______________________________________ **City & Zip** ___________________________

Home Phone: (___) _____-________ **Cell Phone:** (___) _____-________ **Work Phone:** (___) _____-________

Which is the best number to reach you during the day? ❑ Home ❑ Cell ❑ Work

Email Address: ____

Martial Status: ______________________ **Gender:** ❑ Female ❑ Male

Date of Birth: _______/_______/_________ **Race:** ___________ **Social Security Number:** _____-_____-_______

****** *(SS# must be listed IF you want us to file insurance)* ******

Employer: __________________________________ Occupation: __________________________________

How did you learn about our practice? ❑ Doctor ❑ Former Patient ❑ Friend ❑ Internet ❑ Yellow Pages ❑ Other?: ___________________________________

Emergency Contact: _____________________ Relationship: _______________ Phone: (____) ______-________

Person Responsible for bill: ❑ Self ❑ Other: _________________________ Date of Birth: ____/____/______

Address (if different): ____ Phone Number: (____) ______-________

Primary Insurance: ____

Subscriber's Name: _____________________________________ Social Security Number: _____-_____-_______

Patient's Relationship to Subscriber: _________________________ Group Number: ________________________

Policy Number: ____ Co-Payment: ________________________

Secondary Insurance: (if applicable)____

Subscriber's Name: _____________________________________ Social Security Number: _____-_____-_______

Patient's Relationship to Subscriber: _________________________ Group Number: ________________________

Policy Number: ____ Co-Payment: ________________________

Thank you for choosing our office for your Orthopaedic care. Please read and acknowledge the following:

- Payment or co-payment is expected at the time of service; Mastercard, Visa, checks and cash are accepted.
- Frequently, Dr. McConnell will prescribe an orthotic or brace in your recommended care. Many braces are covered by insurance, however, most orthotics, splints, slings and other durable medical equipment are not. We except full payment for items not covered by insurance before you leave our office. On items covered by insurance, we will bill your insurance company, however, you will be responsible for any balance due after their payment.
- We will file your insurance as a courtesy; however, your insurance contract is between you and your insurance carrier. Any questions regarding your contract should be directed to your carrier. If there is a balance on your account we will bill you after your insurance has responded.

I acknowledge that I have read this document in its entirety. I understand and accept the policy regarding insurance coverage and payment responsibility as explained herein by Bright McConnell, III, MD, LLC.

Patient Signature (or guardian, if minor): ___________________________________ ***Date:*** _____/_____/_______

PATIENT INFORMATION RECORD

Medical Allergies ____

____

____

Current Medications ____

____

____

Surgeries ____

____

____

Height __________________ **Weight** __________________

PROTECTED HEALTH INFORMATION (PHI) CONSENT

Please name any individual(s) (spouse, partner, child) who can share your protected health information.

Please list: ____

____

____

____

____

Printed Name of Patient/Guarantor on the Account

____ ________/________/____________

Signature of Patient/Guarantor on the Account **Date**

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