SACRAMENTO ORTHOPEDIC CENTER

2801 K Street, Suite 330
Sacramento, CA 95816
(916) 733-5049

PATIENT INFORMATION

Michael W. Leathers, MD	Lic.# G368320	Alan M. Hirahara, MD, FRCS{C}	Lic.# A674960
Timothy P. Mar, MD	Lic.# G537190	Patrick J. McGahan, MD	Lic.# A104904
Harold B. Strauch, MD	Lic.# A191960		

PCP: ____ DATE: ______________________

PATIENT INFORMATION

NAME: | SOCIAL SECURITY NO:

STREET ADDRESS: | OCCUPATION: | DATE OF INJURY:

CITY: | STATE: | ZIP:

HOME PHONE: ( ) | WORK: ( ) | CELL: ( )

DATE OF BIRTH: | AGE: | ☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ OTHER

REFERRING PHYSICIAN: | PHONE: ( )

EMERGENCY CONTACT FRIEND / RELATIVE: | PHONE: ( )

DRUG ALLERGIES:

GUARANTOR INFORMATION

NAME: | SOCIAL SECURITY NO:

STREET ADDRESS:

CITY: | STATE: | ZIP:

DATE OF BIRTH: | ☐ MALE ☐ FEMALE | RELATIONSHIP TO PATIENT:

HOME PHONE: ( ) | WORK: ( ) | CELL: ( )

PRIMARY INSURANCE

INSURANCE:

SUBSCRIBER:

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT

ID NO: | GROUP:

INSURANCE CO. ADDRESS:

CITY: | STATE: | ZIP:

SECONDARY INSURANCE

INSURANCE:

SUBSCRIBER:

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT

ID NO: | GROUP:

INSURANCE CO. ADDRESS:

CITY: | STATE: | ZIP:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I herby authorize my insurance benefits be paid directly to physician, and authorize the release of any information necessary to process this claim. A copy of this authorization shall be as valid as original.

X ____ ______________

Signature of Insured/Authorized Person Date