

**LANSING ORTHOPEDIC P.C.
PATIENT INFORMATION**

Name: _____ Patient's SS #: _____
 Last First Middle

Address: _____
 Number Street City State Zip

Phone: _____ Birthdate: _____ Age: ___ Sex: F M Marital Status: S M W D

EMPLOYMENT INFO: (IF APPLICABLE)

Patient's Occupation: _____

Employer Name/Address: _____ (Phone) _____

INSURANCE/POLICYHOLDER INFORMATION

Name of Primary Insurance: _____

Name of Insured: _____

Insured's Address: _____

Insured's Employer Name and Address (if other than patient) _____

Insured's SS #: _____ Insured's Birthdate: _____

Name of Secondary Insurance (if applicable): _____

Name of Insured: _____

Insured's Address: _____

Insured's Employer Name and Address (if other than patient) _____

Insured's SS #: _____ Insured's Birthdate: _____

RESPONSIBLE PERSON INFORMATION

Name: _____ Birthdate: _____ SS #: _____

Phone#: _____ Address: _____

Employer Name/Address: _____

PROBLEM/INJURY INFORMATION

Is this Auto Related Work Related Other? Date of injury: _____

Did you contact your insurance agent? Yes No (Claim/File # _____)

Have you applied for Workers' Compensation? Yes No (Claim/File # _____)

Do you plan to apply for Workers' Compensation? Yes No

Are you currently working? Yes No Date you last worked? _____

Have you contacted an attorney regarding this injury? Yes No Do you plan to contact attorney?

(If yes, please indicate name of attorney.) _____

FAMILY/REFERRING PHYSICIAN

Name: _____ Phone #: _____

Other physicians who have treated you for this problem: _____

EMERGENCY CONTACT

Name: _____

(Relationship): _____ Phone#: H) _____ W) _____ Cell) _____

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____