Offices in Crestview and Pensacola
Office: (850) 356-4407
Fax: (850) 807-5487
E-mail: orthospineinstititute1@gmail.com
Website: roberthuangmd.com

Explanation of Insurance Benefits and Patient Responsibility

We verify your insurance benefits as a courtesy to you. However, Orthopaedic Institute of Northwest Florida does not accept responsibility for any incorrect information given by your insurance carrier regarding your insurance benefits or benefit plans. If you have any questions or concerns regarding your policy information please contact your insurance company.

PLEASE FILL THIS FORM OUT IN ITS ENTIRETY

WE REQUIRE THAT ALL CO-PAYS AND CO-INSURANCES DUE BE PAID AT TIME OF SERVICE.

Patient Information

Patient Name: _____

Date of Birth:_____ / _____ / _____

Sex: ☐ **M** ☐ **F**

Parent/Guardian: _____ **Home Phone:** _____

Work: _____ **Cell:** _____

Home Address: _____
Street **City** **State** **Zip Code**

Does the Patient live with someone other than the legal guardian? ☐ **No** ☐ **Yes, relationship:** _____

Referring Physician: _____
Name **Address** **Phone Number**

Primary Care Physician: _____
Name **Address** **Phone Number**

Emergency Contact: _____
Name **Address** **Phone Number**

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Responsible Party Information

IF SAME AS PATIENT, CHECK HERE ☐, LEAVE THIS SECTION BLANK AND CONTINUE ON TO INSURANCE INFORMATION SECTION

Responsible Party Name: _____ _____
Last First Middle initial

Date of Birth: _____/_____/_____ Social Security#: _____Phone Number: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary Health Information:

Insurance Carrier _____

Policy Holder's Name _____ Relationship to Policy Holder _____

Policy Holder's date of birth _____/_____/_____ Policy Holder's Social Security# _____

Policy Holder's Employer: _____
Name **Address** **Phone Number**

Secondary or Other Health Insurance:

Insurance Carrier _____

Policy Holder's Name _____ Relationship to Policy Holder _____

Policy Holder's date of birth _____/_____/_____ Policy Holder's Social Security# _____

Policy Holder's Employer: _____
Name **Address** **Phone Number**

Motor Vehicle Insurance:

Insurance Carrier _____

Adjuster: _____
Name Phone Number

Policy/Case/Claim# _____Date of Accident__/__/ __ Place of Accident: _____

Is this visit authorized? _____By whom? _____ Authorization# _____

Patient, Parent, or Legal Guardian: _____

Signature: _____

Date: _____