CHART # _____

ADULT PATIENT INFORMATION
ORTHOPEDIC GROUP OF BIRMINGHAM, P.C.

PLEASE READ CAREFULLY AND COMPLETE ITY AS THOROUGHLY AS POSSIBLE. THIS IS TO ENSURE YOU THE BEST SERVICE AVAILABLE.

PLEASE PRINT

PATIENTS NAME: _____ **AGE:** _____

DOB: _____ S S #: _____ MARITAL STATUS: S M W D SEP SEX: M F

ST. ADDRESS: _____ MAILING ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____-_____

TELEPHONE: (H) _____ (W) _____ (C) _____

*CHECK HERE TO ACCEPT TEXT MESSAGE REMINDERS ☐ PHONE CARRIER _____

*Charges May Apply

EMAIL ADDRESS: _____

PATIENT'S EMPLOYER: _____ ADDRESS: _____

SPOUSE'S NAME: _____ BIRTHDATE: _____ SS#: _____

EMPLOYER: _____ TELEPHONE: (W) _____ (C) _____

DOCTOR: _____ **PHONE** _____ **FAX** _____

NAME OF PHARMACY: _____ **PHONE #:** _____
ADDRESS & ZIP _____

EMERGENCY CONTACTS: (Who has authorization to speak to the office in regards to you & your care?)
1. _____ **Home/ Cell #'s** _____
2. _____ **Home/ Cell #'s** _____

PATIENT PORTAL: PLEASE CIRCLE ONE **YES, I am interested.** **NO, I am not interested.**

INSURANCE INFORMATION: PLEASE COMPLETE THIS SECTION:
PRIMARY INSURANCE: _____

CLAIMS OFFICE ADDRESS: _____

POLICY HOLDER NAME: _____ SS#: _____

DATE OF BIRTH: _____ EFFECTIVE DATE: _____ **PLEASE**

CONTRACT #: _____ GROUP #: _____ **PRESENT**

SECONDARY INSURANCE: _____ **INSURANCE**

CLAIMS OFFICE ADDRESS: _____ **CARD (S)**

POLICY HOLDER NAME: _____ SS#: _____

DATE OF BIRTH: _____ EFFECTIVE DATE: _____

CONTRACT #: _____ GROUP #: _____

_____ _____

SIGNATURE **DATE**