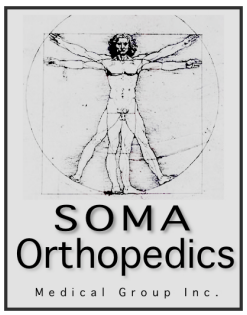

Date:_____

Date of Birth___/____/_____ M__ F__

Marital Status: (S)___ (M)___ (SO)___

Social Security No._____

Name: (Last)_____(First)_____(MI)_____

Address:_____
Street Apt No. City State Zip

Home Phone: (_____)_____Work:(_____)_____Cell:(_____)_____

Primary Care Provider:_____ Phone No: (____)_____

Employer:_____

- Is your injury **work** related? Y__ N__
  If yes, do NOT complete the insurance section, but our Worker's Compensation Form instead.

- Is your injury related to a **Motor Vehicle Accident**? Y__ N__
  If yes, do NOT complete the insurance section. Payment is due at the time of service.

MEDICAL INSURANCE INFORMATION:

Primary Insurance:_____ID#_____

Subscriber Name:_____ Subscriber SS#_____

Subscriber Date of Birth:_____Relationship to Patient:_____

Secondary Insurance:_____ID#_____

Subscriber Name:_____ Subscriber SS#_____

Subscriber Date of Birth:_____Relationship to Patient:_____

IF WE ARE BILLING YOUR MEDICAL INSURANCE, YOU MUST PROVIDE A CURRENT INSURANCE CARD AND SIGN THE AUTHORIZATIONS BELOW:

I authorize payment of medical benefits to SOMA Orthopedics Medical Group, Inc. or supplier of services. I authorize release of any medical information necessary to process this claim. I understand that my physician will make every effort to bill my insurance for services provided, but that proof of coverage and financial responsibility ultimately lie with me.

_____
Signed Date

MISSED APPOINTMENT POLICY: All appointments must be cancelled at least 24 hours prior to the scheduled appointment time or a $35.00 fee will be changed. $250 fee charged for missed procedures/surgeries.
FORMS: There is an additional charge to complete many forms (DMV placard $15, State Disability $25, all other forms $20/page). Payment to be made prior to form completion.

I have read and understand all the information on this form.

_____
Patient Signature Date

Guardian/Representative_____
Print Name Signature Date