



Date: _____

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

Date of Birth ___/___/___ M ___ F ___ Social Security #: _____

Address: _____
Street Apt No. City State Zip

Home Phone: (____) _____ Work:(____) _____ Cell:(____) _____

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

How did you learn about our office: MD ___ Friend ___ Yelp ___ Radio ___ Other _____

● 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 charged. \$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