

O. E. KALTENBAUGH, M.D.

Orthopaedic Surgery and Sports Medicine
307 St. John's Way • Lewiston, Idaho 83501 • (208) 746-5132

PATIENT'S FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

MARTIAL STATUS: SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED ___

SOC. SEC. # _____ HOME TELEPHONE _____

PATIENT'S OR PARENTS EMPLOYER _____ WORK TELEPHONE _____

SPOUSE OR PARENTS NAME _____ EMPLOYER _____

RELATIVE OR FRIEND NOT LIVING WITH YOU

NAME _____ PHONE # _____ RELATIONSHIP _____

GUARANTOR (NAME THE INSURANCE POLICY IS IN)

NAME _____ SOC. SEC. # _____

BIRTH DATE _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO. AND NUMBER: _____

NAME OF SECONDARY INSURANCE CO. AND NUMBER: _____

ACCIDENT INFORMATION (Please Circle)

WAS THIS AN ACCIDENT? YES NO DATE OF ACCIDENT _____

PLACE OF ACCIDENT: HOME WORK SCHOOL AUTO OTHER: _____

BRIEF DESCRIPTION OF ACCIDENT: _____

REFERRED BY _____ PHONE# _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE OF MEDICAL INFORMATION:

I hereby authorize payment to Orie E. Kaltenbaugh, M.D. of any benefits payable for services as described on the billing statement. I authorize release to the health care financing administration, my insurance company, or companies, any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for payment regardless of any insurance contracts or agreements. I further understand that if this account should require the services of an outside agency to collect payment due this office, then all information necessary to collect this debt will be provided to that agency.

My signature certifies that I have read and understand the above.

SIGNATURE _____ **DATE** _____