

**Wake Orthopaedics**  
**PATIENT INFORMATION FORM**

First Name	Middle Initial	Last Name		
Street Address		City	State	Zip Code
County	Email Address			
Home Phone (    )	Work Phone (    )	Date of Birth	Age	Social Security #
Marital Status	Gender Male    Female	Employer/School Name & Address		
Family Physician		Referring Physician/Referral Source		
Person to Contact in Case of Emergency		Relationship	Phone Number (    )	
Spouse/Parent Name		Social Security #	Phone Number (    )	
Spouse/Parent Address		City	State	Zip Code
<b>Problem Information</b>				
Injured/ Painful Area: _____ ( ) Right ( ) Left    Date of Injury/Onset: _____				
Medication Allergies: No ( ) Yes ( ) If "Yes" List Allergies _____				
Was this a motor vehicle accident? Yes    No		If yes, provide name of Insurance Company		
Was this a work-related injury? Yes    No		Employer at time of injury		
<b>Please Complete Insurance Information</b>				
Insurance Company		Policy Number		
Subscriber's Name		Subscribers Social Security # & DOB		
Subscriber's Employer				
Secondary Insurance Company		Policy Number		
Subscriber's Name		Subscribers Social Security # & DOB		

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY:**

I authorize the release of information to my referring or family physician and/or that which is necessary to file claims to the insurance carrier and the billing of my account for payment. I understand that you may be transmitting any records electronically, and I absolve all parties of any liability relating to such transmission of said records. I authorize my insurance carrier to make payment directly to Wake Orthopaedics, LLC. I understand that I am responsible for any remaining balance due on my account not covered by my insurance carrier. Thus, if the account balance is not satisfied within 30 days after the first notification, the account may be referred for legal action. I consent to the treatment rendered to me under the general/special care of the attending physician.

**Signature** \_\_\_\_\_      **Date** \_\_\_\_\_