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LINDSEY A.WINTERSCHEIDT, PA-C

Referring Physician:______________________ Primary Physician:______________________

Patient Name:______________ ______ ______________ SS#:______________
(First) (MI) (Last)

Home Address:______________________ P.O. Box:______________

City, St.:______________________ Zip Code:______________

Patient e-mail address:______________________ Age:_____ Sex:_____ Marital Status: S M W D

Home Phone: ( ) ______________ Cell Phone: ( ) ______________ Birth Date:______________

Employer:______________ Work Phone: ( ) ______________ Spouse Name:______________

Spouse Employer:______________ Work Phone: ( ) ______________ Spouse DOB:______________

Worker's Compensation Related: Yes / No **Auto Related:** Yes / No **Other Liability Related:** Yes / No

Due to Injury: Yes / No Injury Date:______________ Where did injury occur:______________

What body part injured:______________ How did injury occur:______________

What are we seeing you for today?______________________

-Complete if Student or Minor-

Father Information

Name:______________________

Address:______________________

City, St., Zip:______________________

Home Phone: ( ) ______________

Work Phone: ( ) ______________

Employer:______________________

SS#:______________ DOB:______________

Mother Information

Name:______________________

Address:______________________

City, St., Zip:______________________

Home Phone: ( ) ______________

Work Phone: ( ) ______________

Employer:______________________

SS#:______________ DOB:______________

-Person Responsible for Payment of Account-

Name:______________________ Relationship:______________

Address:______________________ Home Phone: ( ) ______________

City, St., Zip:______________________ Other Phone: ( ) ______________

-Insurance Information-

Please Present Card(s) for Copying

Primary Insurance:______________ Policy #:______________ Group #:______________

Ins. Address:______________________ Ins. Phone:______________

Card Holder's Name:______________ DOB:______________ SS#:______________

Secondary Insurance:______________ Policy #:______________ Group #:______________

Ins. Address:______________________ Ins. Phone:______________

Card Holder's Name:______________ DOB:______________ SS#:______________

Other Insurance:______________ Policy #:______________ Group #:______________

Ins. Address:______________________ Ins. Phone:______________

Card Holder's Name:______________ DOB:______________ SS#:______________

I hereby give my consent to Tallgrass Orthopedic & Sports Medicine and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If Tallgrass Orthopedic & Sports Medicine chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

Signature of Patient or Patient's Representative:______________________ Date:______________