Patient Name____
Last First Middle
Address_____________________________________City: _____________________Zip:_______________
Phone #_________________Cell#________________Birthday_________________Age______ Sex: ______
Marital Status: Single______Married______Widow______ Social Security#_________________________
Employer:____ Work Phone #____________________________

Spouse/Legal Guardian____
Last First Middle
Phone #_________________Cell#________________Birthday_________________Age______Sex:_______
Employer:_________________________Work Phone #___________Social Security #__________________

Nearest friend or relative not living with you:_________________________________Phone#_____________
Referring Physician_________________________________Family Physician__________________________

Person Responsible for Payment:____
Date of Injury:__________ **If injury** is it: Work Related______Auto Accident_______Other_________

We are happy to bill your insurance as a courtesy to you, however; it is the patient's/and or legal guardian's responsibility to insure payment for all medical services rendered.

PRIMARY INSURANCE INFORMATION:
Company Name_______________________________Subscriber ID#_____________Group #_____________
Policy Holder____Birthday_________________________
Insured Address____

SECONDARY INSURANCE INFORMATION:
Company Name_______________________________Subscriber ID#_____________Group #_____________
Policy Holder____ Birthday______________________
Insured Address____

I accept the responsibility for payment to Gregory E. Biddulph, M.D. and /or Casey I. Huntsman, M.D. and/or Joel B. Whiting, PA-C A.T.C. for any portion of the account that the insurance carrier does not pay. In the event that I do not have health insurance, I agree to accept responsibility for payment of my account, with a payment applied to the account each month. All balances over 120 days will be assessed an interest rate of 12% per month payable by the patient.

I authorize Gregory E. Biddulph, M.D. and /or Casey I. Huntsman, M.D. and/or Joel B. Whiting , PA-C A.T.C. to release any information regarding my medical care to the insurance carriers, I authorize any medical care facility to provide all information on my medical history to Gregory E. Biddulph, M.D. and /or Casey I. Huntsman, M.D. and /or Joel B. Whiting, PA-C A.T.C.

I assign to Biddulph and/or Huntsman Orthapaedics, P.A. all benefits of surgical and medical care, payable under the above policy.

Date:_____________________________Responsibile Party____

Revised 9-2007