ZEIDERS orthopedics

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Edmond, OK 73013
(O) 405-509-7370
(F) 405-509-7373

PATIENT INFORMATION (please print)

Patient Name (Last) _____ **(First)** _____ **(MI)**_____
Social Security Number _____-_____-_____ Date of Birth MM _____ DD _____ YYYY _____
Address _____
City_____ State_____ Zip Code_____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address_____ Sex ☐ Female ☐ Male ☐ Transgender
Employer Name _____
☐ Full time ☐ Part time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Active Military ☐ Student

Race ☐ American Indian or Alaska Native ☐ Black or African American ☐ White
☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined
Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian

Do you have a living will? ☐ Yes ☐ No Do you have a DNR? ☐ Yes ☐ No

Emergency Contact First Name _____ Last Name _____
Phone Number_____ Relationship to patient_____ ☐ Guardian

Please list the name and relationship of person(s) to which we may release your medical information to:
Name _____ Relationship _____
Name_____ Relationship _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐ Self ☐ Guarantor ☐ Another patient **Check here if information is same as patient** ☐
Responsible Party Name: (Last) _____ (First) _____ (MI)_____
Social Security Number _____-_____-_____ Date of Birth MM _____ DD _____ YYYY _____
Address _____
City_____ State_____ Zip Code_____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address_____ Sex ☐ Female ☐ Male ☐ Transgender
Employer Name _____ Employer Phone Number: _____

PRIMARY INSURANCE INFORMATION (PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK AT CHECK IN)

Insurance Company _____ Phone Number _____
Name of Insured _____ Relationship to patient _____
Date of Birth _____ Subscriber ID (Policy Number) _____ Group ID _____
Effective Date _____ Termination Date _____ Copay Amount _____

SECONDARY INSURANCE INFORMATION (PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK AT CHECK IN)

Insurance Company _____ Phone Number _____
Name of Insured _____ Relationship to patient _____
Date of Birth _____ Subscriber ID (Policy Number) _____ Group ID _____
Effective Date _____ Termination Date _____ Copay Amount _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____
Patient (or Responsible Party) Signature **Date**