High Desert Orthopedics
AND SPORTS MEDICINE
RAMA T. PATHI M.D., F.A.C.S.

# PATIENT INFORMATION SHEET

***Please Fill Out Completely***

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Board Certified in Orthopedic Surgery and Hand Surgery
Joint Replacement & Sports Injuries
Physical Therapy

Date:_____

Name:_____ Birth Date:_____ Age:_____
Last First Middle

Address:_____ Home Phone:_____
Street City Zip

Marital Status: S M W D Sep. (Circle) Sex: M F Social Security #:_____

Is Patient a Minor/Student: Yes No Parental Marital Status: M D W Sep. Father SS#:_____ Mother SS#:_____

Spouse's Name:_____ SS #:_____ Employer_____ Work Phone:_____

Close Relative or Friend:_____ Relation:_____ Phone:_____

**Patient's Employer** Name:_____ Work Phone:_____

Employers Address:_____ Occupation:_____

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**Primary Insurance**

Name of Insurance Co.:_____
Policy#:_____ Group#:_____
Address:_____
Policy Holder's Name:_____
Date of Birth:_____
Policy Holder's Employer:_____
Phone #:_____

**Secondary / Supplemental Insurance**

Name of Insurance Co.:_____
Policy#:_____ Group#:_____
Address:_____
Policy Holder's Name:_____
Date of Birth:_____
Policy Holder's Employer:_____
Phone #:_____

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Allergies:_____
Medical Conditions:_____

| **Surgeries**: | *Name* | *Date* | **Medications**: | *Name* | *Dosage* |
|---|---|---|---|---|---|
| 1. | | | 1. | | |
| 2. | | | 2. | | |
| 3. | | | 3. | | |
| 4. | | | 4. | | |
| 5. | | | 5. | | |

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**Present Complaint or Injury Is:**

☐ Personal Injury ☐ Work Related ☐ Auto ☐ Third party

Date of Injury:_____ Part of Body Affected:_____
Where / How Injury Happened:_____

_____

Any Previous Treatment For This Problem:_____

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**Auto Accident and Industrial Injury Only**

Prior Auto Injuries: When:_____ How:_____ Treatment:_____

Prior Industrial Injuries: When:_____ How:_____ Treatment:_____

Current Job:_____ Title:_____ Years:_____ Hrs Worked Per Week:_____

Your Job Req.'s How Many Hrs Per Day: __Sitting __Walking __Standing Up __Climbing __Lifting (__Lbs.)

Currently Are You: [ ]Off Work Since:_____ [ ]Working [ ]Regular [ ]Light Duty

# FINANCIAL POLICY TO OUR OFFICE

It is our office policy to bill your insurance carrier(s), as a courtesy to you. The BALANCE OF YOUR ACCOUNT will be YOUR RESPONSIBILITY, if we have not received payment within 60 DAYS after insurance has been billed by us. Over due accounts over ninety (90) days will be charged 1.50% interest on the unpaid balance (computed monthly). **All co-payments and deductibles are due and payable before office visit**.

Date_____Signature_____

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Date_____Signature_____

I hereby authorize DR. RAMA T. PATHI M.D. to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to DR. RAMA T. PATHI M.D. (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing.

Date_____Signature_____

## I am authorizing my medical information to be released on my behalf:

Name:_____ Relationship:_____

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