DONALD R. GORE, MD
D. SCOTT SELLINGER, MD
KEVIN J. GASSNER, MD
SCOTT T. GLAESER, MD
BRUCE A. VAN DOMMELEN, MD

2920 Superior Avenue
SHEBOYGAN ♦WISCONSIN 53081

Date:_______________________________ Patient's Soc. Sec #________________________

Patient's Name____________________________________ Previous Names________________________
(Legal Given) (First) (Middle Initial) (Last)

Address____ Phone #__________________________________

City, State, Zip__________________________________ Birth Date________________ Age____________

Male______ Female______ Single______ Married______ Divorced______ Widowed______

Patient's Employer__________________________________ Shift ___1st ___2nd ___3rd

Address____ Phone #__________________________________

Occupation______________________________________ How long at present job?____________________

Parent or Spouse Name(s) 1)____________________ 2)______________________________________

Parent or Spouse Employer(s) 1)____________________ 2)______________________________________

Work Phone # 1)____________________ 2)______________________________________

Person outside of home to contact____

Address____

Phone #____

Date of Injury / Accident______________________________

Referred By____ Send Report ____ No Yes____

Family M.D.____ Send Report ____ No Yes____

PLEASE COMPLETE BOTH PAGES OF THIS FORM →

AUTHORIZATION FOR RELEASE OF INFORMATION
AND ASSIGNMENT OF BENEFITS

I hereby authorize release of any medical information acquired in the course of my exam or treatment necessary to process insurance claims and assign payment of medical benefits directly to Sheboygan Orthopaedic Associates, S.C.

I understand that I am financially responsible for any remaining account balance after insurance benefits are paid.

____
Signature

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins. Co. Name ____________	Ins. Co. Name ____________
Address ____________	Address ____________
Subscriber Name ____________	Subscriber Name ____________
Subs. Birth Date ______ Eff. Date ______	Subs. Birth Date ______ Eff. Date ______
Medicare or Ins. I.D. Number ______ Group # ______	Medicare or Ins. I.D. Number ______ Group # ______
Employer or Group Name ____________	Employer or Group Name ____________

Please provide us with a copy of your insurance card for photocopying.

WORKER'S COMPENSATION INSURANCE

Complete if Applicable

Is this problem work related? ____ Yes ____ No

Date of Accident ____________

Did you report it? ____ Yes ____ No

To Whom? ____________

Explain problem & how it happened ____________

Employer's Name ____________

Work Phone # ____________

Address ____________

Work. Comp. Ins. Co. Name ____________

Claim # ____________

Address ____________

List all doctors who have treated you for this incident ____________

AUTO OR LIABILITY INSURANCE

Complete if Applicable

Date of Accident ____________

Explain how and where accident occurred ____________

Claim should be filed with: ____________

Address ____________

Policy or Claim Number ____________

Policy Subscriber Name ____________

Contact Person: ____________

Phone # ____________

Address ____________

Name of Attorney (if applicable) ____________

Phone # ____________

Address ____________

Thank You