



TAX I.D. # 83-0322741

Teton Orthopaedics

555 East Broadway
Jackson, WY 83001-0490
(307) 733-3900

PATIENT INFORMATION

Form section for Patient Information containing fields for Name, MRN, SSN#, Birthdate, Language, Sex, Mailing Address, Referring Physician, Home Phone, Day Phone, Email Address, Primary Care Provider, City, State, Zip, Marital Status, Student Status, Smoker, Veteran, Emergency Contact Name, Contact Phone, Home Phone, Primary Employer, Secondary Employer, Address, Work Phone.

RESPONSIBLE PARTY INFORMATION (if Different than above)

Form section for Responsible Party Information containing fields for Name, SSN#, Birthdate, Language, Sex, Mailing Address, Secondary/Billing Address, Home Phone, Day Phone, Email Address, City, State, Zip, Marital Status, Student Status, Smoker, Veteran, Primary Care Provider, Home Phone, Relationship to Patient.

PRIMARY INSURANCE

Form section for Primary Insurance containing fields for Name of Insurance Company, Policy#, Name of Insured, Group#, Address of Insurance Company, Copay Amt, City, State, Zip, Phone, Deductible, Relationship to Patient, Effective Date, Expiration Date.

SECONDARY INSURANCE (if Applicable)

Form section for Secondary Insurance containing fields for Name of Insurance Company, Policy#, Name of Insured, Group#, Address of Insurance Company, Copay Amt, City, State, Zip, Phone, Deductible, Relationship to Patient, Effective Date, Expiration Date.

LOCAL PHONE \_\_\_\_\_ EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

Which MD are you seeing? \_\_\_\_\_

I hereby consent to routine care and treatment as necessary. I hereby assign all medical and/or surgical benefits to Teton Orthopaedics. A photo copy of this document is to be considered as valid as an original. I understand that I am financially responsible for all charges. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNATURE OF PATIENT/GUARDIAN

DATE