

Place a check mark beside your doctor's name

- Steven J. Lancaster, MD
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Patient Information Sheet



Patient Information (please fill in the following information about the patient)

Name _____ Emergency Contact _____
 Address _____ Apt # _____ Phone _____
 City _____ State _____ Zip _____
 Social Security Number _____ - _____ - _____ Primary Care Physician Name _____
 Age _____ Date of Birth ____/____/____ Primary Care Phone Number _____
 Male Female

Phone Numbers

Home _____
 Cell _____
 Work _____

If patient is **under 18** please fill in the following:

Father's Name _____
 Father's Date of Birth ____/____/____
 Mother's Name _____
 Mother's Date of Birth ____/____/____

If patient is a **student over 18**, please name the school patient is attending _____

Primary Insurance Information

Insurance Name _____
 ID or Claim # _____
 Effective Date _____
 Group _____
 Address where _____
 to send claim _____
 Phone _____

Subscriber Information

Subscriber's Name _____
 Male Female Date of Birth ____/____/____
 Social Security Number _____ - _____ - _____
 Employer _____
 Employer's Address _____

Relationship to Patient Self Spouse Dependent Child Stepchild Other _____

Secondary Insurance Information

Insurance Name _____
 ID or Claim # _____
 Effective Date _____
 Group _____
 Address where _____
 to send claim _____
 Phone _____

Subscriber Information

Subscriber's Name _____
 Male Female Date of Birth ____/____/____
 Social Security Number _____ - _____ - _____
 Employer _____
 Employer's Address _____

Relationship to Patient Self Spouse Dependent Child Stepchild Other _____

- I authorize Jacksonville Orthopaedic Institute (JOI) – Beaches to provide treatment for the above said patient.
- I hereby authorize the release of information necessary to file a claim with my insurance company and do hereby authorize assignment of my benefits payable to me to JOI – Beaches.
- I understand that if my Workers' Comp or Auto claim is denied, I am financially responsible for all charges incurred.
- I understand that I am financially responsible for any balance not covered by my insurance carrier. I also understand that if a referral is needed, I am responsible for getting that referral before my appointment at JOI .
- A copy of this signature is as valid as the original signature.

Signature of Patient/Responsible Party Date ____/____/____

Minor's Name (if applicable) Revised 05-28-08