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APPALACHIAN ORTHOPEDIC CENTER  
PATIENT BILLING INFORMATION FORM

1 Dunwoody Drive  
Carlisle, PA 17015  
Telephone: 717-249-6112  
Fax: 717-249-6235

PLEASE PRINT ALL INFORMATION

Patient Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_ Date: \_\_\_\_\_  
Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Telephone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widow \_\_\_ Spouse's Name: \_\_\_\_\_  
Race: \_\_\_\_\_ Origin: Hispanic: \_\_\_ Non Hispanic: \_\_\_ Decline/Unknown: \_\_\_ Language: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

**WORKER'S COMPENSATION, AUTO ACCIDENT, OR LIABILITY INFORMATION**  
Complete **ONLY** if today's visit pertains to an injury at work, an auto accident, or a Liability Claim

Workman's Compensation Injury: Yes \_\_\_ No \_\_\_ Auto Accident Injury: Yes \_\_\_ No \_\_\_ Liability Claim: Yes \_\_\_ No \_\_\_  
Claim Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ Body Area (s) Injured: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**PRIMARY HEALTH INSURANCE**

Name of Company: \_\_\_\_\_  
Policy or Id Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**POLICY HOLDER'S INFORMATION**

Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_

**SECONDARY HEALTH INSURANCE**

Name of Company: \_\_\_\_\_  
Policy or Id Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**POLICY HOLDER'S INFORMATION**

Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_

Complete **ONLY** if patient is under 18 **AND** your address is different than the patients

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Telephone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

I authorize Appalachian Orthopedic Center, Ltd. to accept this signature on file as authorization to submit a claim to my insurance company. My signature authorizes payment to be made directly to Appalachian Orthopedic Center Ltd. If Workman's Compensation or Auto Accident, I authorize the release of my medical records, regardless of insurance benefits. I understand that I remain financially responsible for all fees for services rendered.

Acknowledgement of Receipt of Notice: I acknowledge receipt of notice of privacy practice for Appalachian Orthopedic Center Ltd.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE