BONE & JOINT ASSOCIATES, PLLC

Anthony D. McBride, MD ♦ M. B. Moore, MD ♦ Aaron J. Wallace, MD

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Mountain Home, AR 72653

Office: 870-424-4710
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PATIENT INFORMATION – Please print and fill out completely Today's Date___________________

Name ____ Birthdate____/____/____ Age ______ Sex ____
Home Address ___________________________________City_______________ State ____ Zip _________
Home Phone # _________________ Cell phone # ________________ Social Security # ____________________
Marital Status: Single Married Divorced Widowed Separated Spouse's name____________________
Employer or School ____ Phone #_______________
Employer / School Address ________________________________City____________ State ____ Zip _______

PERSON RESPONSIBLE FOR BILL

Name ___________________________________ Relationship ___________ Social Security # ___________
Address _____________________________________ City __________________ State ____ Zip _________
Home Phone ___________ Business Phone ____________ Resp. Party Employer________________________
Employer Address __________________________________City _____________ State _____ Zip ________

INSURANCE INFORMATION –

Medicare # ________________________________ Medicaid # ___________________________________
Blue Cross/Blue Shield: Group # _______________________ ID # __________________________________
Address of Blue Cross/Blue Shield : Street____
City ____ State __________________ Zip __________
OTHER Insurance Coverage ____
Group # ____________________ID # _____________________ Contract # (if any) ___________________
Street Address of Insurance Company ____
City ____ State ________ Zip _____________

Who is your personal or family physician? ____
Address ______________________________________ City ________________ State ______ Zip ________

EMERGENCY CONTACT: Please give the name and phone number of a friend or relative that does not live with you.
Name ____ Phone ________________________

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION AND CONSENT FOR TREATMENT:

I hereby authorize payment directly to M.B. Moore, MD / A.D. McBride, MD / A.J. Wallace, MD for services rendered and supplies provided by M.B. Moore, MD / A.D. McBride, MD. / A.J. Wallace, MD I understand that this assignment is for all benefits otherwise payable to me, but not to exceed my indebtedness to physician. I authorize M.B. Moore, MD / A.D. McBride, MD / A.J. Wallace, MD to release any information acquired in the course of treatment or examination for the purpose of treatment, payment or other healthcare operations. I understand that I am financially responsible for charges not covered by this assignment.

I hereby consent to be treated by M.B. Moore, MD / A.D. McBride, MD / A.J. Wallace, MD and staff. The undersigned consents to any x-ray, examination, laboratory procedures or medical services rendered under the general or specific instructions of the Doctor.

AGE OF CONSENT – Where minors are involved, the following shall prevail:

1. The consent of parent or legal guardian is required if patient is unmarried and under the age of 18.
2. If a patient under age 18 is married, or has been married and such marriage has been dissolved by dissolution or annulment, then the consent of a parent or legal guardian is NOT required.

The undersigned hereby acknowledges that he/she has read and fully understands the foregoing, and has voluntarily executed this document. The undersigned further acknowledges that he/she is the patient, or is duly authorized by and on behalf of the patient to execute this document, and accepts its terms personally and upon patient's behalf. The release of information set for hereinabove is valid, and the assignment of benefits and financial agreement is valid and binding until final settlement of account is received.

SIGNATURE ____ DATE ________________