MEDICAL CENTER FOR BONE AND JOINT DISORDERS, INC.

400 N. MOUNTAIN AVE., SUITE 310, UPLAND, CALIFORNIA 91786 (909) 920-0876 FAX: (909) 946-4926

Patient's Last Name	First	Int.	Responsible Party
Birth Date / Age / Sex	CA Driver's License #		PATIENT STATUS ☐ Single ☐ Married ☐ Other _____
Social Security No.	Spouse's Name (or Mother's)		☐ Employed ☐ Full-time Student ☐ Part-time Student
Street Address	City/State	Zip	Phone No.
Mailing Address (if different)	City/State		Zip
Patient's Employer	Address		Phone No.
Spouse's Employer	Address		Phone No.

Patient's Occupation — Patients E-mail Address:

Name of Referring Physician	Phone No.	Family Physician	Phone No.
Is this a new illness? ☐ Yes ☐ No / Were you injured? ☐ Yes ☐ No	How Injured? ☐ Work ☐ Auto ☐ Other		Date of Injury / Onset

Briefly describe your problem

Name of Relative or Friend and Phone No.

Primary Insurance Co. & Address		Secondary Insurance & Address	
I.D. No. /or S.S. No.	Group No.	I.D. No./S.S. No.	Group No.
PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ other		PATIENT RELATIONSHIP TO INSURED ☐ Self ☐Spouse ☐ Child ☐ other	
INSURED'S NAME (Last Name, First Name, Middle Initial)		INSURED'S NAME (Last Name, First Name, Middle Initial)	
INSURED'S ADDRESS (No. Street)		INSURED'S ADDRESS (No. Street)	
CITY / STATE / ZIP		CITY / STATE / ZIP	
DATE OF BIRTH	TELEPHONE (INCLUDE AREA CODE)	DATE OF BIRTH	TELEPHONE (INCLUDE AREA CODE)
Insured's Employer & Phone No.		Insured's Employer & Phone No.	

I hereby consent to treatment by Medical Center for Bone and Joint Disorders/Physical Therapy. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X: _____ _____

Signature of patient or parent if minor — Date