

**Welcome to Miller Orthopaedics**

**PATIENT INFORMATION**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status: Single, Married, Widowed, Divorced  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Work# \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_ Phone# \_\_\_\_\_  
Date of accident, injury or first symptom \_\_\_\_\_

**RESPONSIBLE PARTY OR SPOUSE INFORMATION**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ SSN # \_\_\_\_\_  
Work# \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Friend or Relative Not Living with You: \_\_\_\_\_ Phone# \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_  
Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Relationship to Insured: Self, Spouse, Dependent  
Insured's Employer/Phone# \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Insured's SS# \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_  
Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Relationship to Insured: Self, Spouse, Dependent  
Insured's Employer/Phone# \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Insured's SS# \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

**How did you hear about our practice? Relative, Friend, Telephone Book, Website, Physician Referral, Other**

**Assignment of Benefits:** I authorize payment of benefits from my insurance company to be paid directly to Steven C Miller, MD, PLLC dba Miller Orthopaedics. I also authorize Steven C Miller, MD, PLLC dba Miller Orthopaedics to release to my insurance company any and all information necessary for the processing of insurance claims.

Signature \_\_\_\_\_ Date: \_\_\_\_\_