

SOUTHERN ILLINOIS ORTHOPEDIC CENTER

510 Lincoln Drive
Herrin, IL. 62948
(618) 997-3100

Patient Name _____

Address _____
Street or P.O. Box #
City, State, Zip Code

Male/Female Soc. Sec# _____ Date of Birth _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Work Related? _____ Injury Date and Time _____

How did injury/accident happen? _____

Employer _____ Employer Address _____ Employer's Phone _____

Spouse's Name _____ Spouse's Employer _____ Employer's Phone _____

Insured Name and Address if Different From Above: _____

Relation to Insured _____ Insured SSN _____

Insured Date of Birth _____

Insured Employer _____ Insured Phone _____

Emergency Contact (Name and Phone No.) _____

Insurance Information (Primary)	(Secondary)
Insurance Carrier _____	Insurance Carrier _____
Insurance Address _____	Insurance Address _____
Insurance Phone # _____	Insurance Phone # _____
Policy Holder Name _____	Policy Holder Name _____
Insurance Policy# _____	Insurance Policy# _____

SOUTHERN ILLINOIS ORTHOPEDIC CENTER: The physicians of Southern Orthopedic Associates have ownership in Southern Illinois Orthopedic Center. Your physician may use the services of Southern Illinois Orthopedic Center should you need an outpatient surgery. Please refer to the Billing Questions Form regarding surgical/doctor fees and billing processes.

Personal Belongings: Southern Illinois Orthopedic Center, L.L.C. is not responsible for any loss or damage to any money, jewelry, documents, garments, dentures, eye glasses, prosthesis, or any other items of personal property brought on the premises. Any unclaimed personal property will be discarded without notice 30 days from the last date of service.

Personal Injury Cases: In all cases where it is alleged that a third party is or may be liable for the medical services and medical expenses, the patient, and any and all other responsible parties, remain primarily liable and responsible for the immediate payment of the account. Payment of the charges for the medical services, or other satisfactory payment arrangements, is expected at the time the services are rendered.

X _____
Patient or Responsible Party

X _____
Date