Bright McConnell, III, MD, LLC

Welcome to the office of Bright McConnell, III, MD

Patient Information Record

Today's Date: __________________ **Patient's Name**: ____

Brief description of reason for today's visit:____

____

Street Address: ___________________________________City & Zip ______________________________

Home Phone: (___) ____-________ Cell Phone: (___) ____-________ Work Phone: (___) ____-________

Which is the best number to reach you at during the day? ☐ Home ☐ Cell ☐ Work

Email Address: ____

Martial Status: ______________________ Gender: ☐ Female ☐ Male

Date of Birth: ____/____/________ Race: ___________ Social Security Number: _____-____-______

Employer: _________________________________Occupation: ______________________________

How did you learn about our practice? Doctor/ Former Patient/ Friend/ Internet/ Yellow Pages/ Other?: ________

Emergency Contact: __________________Relationship: ______________ Phone: (___) ____-________

Person Responsible for bill: ☐ Self Other: _________________ Date of Birth: ___/___/______

Address (if different): _________________________________ Phone number: (___) ____-___________

Primary Insurance: ____

Subscriber's Name: ___________________________ Social Security Number: _____-_____-_______

Patient's Relationship to Subscriber: _____________ Group Number: _________________________

Policy Number: _______________________________ Co-Payment: ___________________________

Secondary Insurance: (if applicable)____

Subscriber's Name: ___________________________ Social Security Number: _____-_____-_______

Patient's Relationship to Subscriber: _____________ Group Number: _________________________

Policy Number: _______________________________ Co-Payment: ___________________________

Signature of Patient or Legal Guardian: ____

Please check method of payment: ☐ Cash ☐ Check ☐ Mastercard/Visa

Credit Card Number: ______________________________ Expiration Date: ___________________

Credit Card Authorization Signature: ____

Please present you insurance card(s) to the receptionist so we may help you with your insurance reimbursement.

Thank you for choosing our office for you Orthopaedic care. Please read and acknowledge the following:

- Payment or co-payment is expected at the time of service; Mastercard, Visa, checks and cash are accepted.
- Frequently, Dr. McConnell will prescribe an orthotic or brace in your recommended care. Many braces are covered by insurance, however, most orthotics, splints, slings and other durable medical equipment are not. We except full payment for items not by insurance before you leave our office. On items covered by insurance, we will bill your insurance company, however, you will be responsible for any balance due after their payment.

I acknowledge that I have read this document in its entirety. I understand and accept the policy regarding insurance coverage and payment responsibility as explained herein by Bright McConnell, III, MD, LLC.

Patient Signature (or guardian, if minor): ___________________________________ Date: ____/_____/_____