John M. Conner, M.D.

Board Certified Orthopaedic Surgeon

PATIENT INFORMATION

Last Name:_____First Name:_____Middle:_____Sex:____
Address:_____City:_____State:_____Zip:_____
Home Phone:( )_____ Work Phone:( )_____ Cell Phone( )_____
DOB:___/___/___SS#:____-_____-_____ Marital Status:__ Single__ Married__ Divorced__ Widowed
Preferred Pharmacy/Location:_____
Email Address:_____Race:_____Ethnicity:_____
Emergency Contact:_____Relationship:_____
Phone:( )_____ Type of Phone: __Home__ Work__ Cell
Employer:_____
Address:_____City:_____State:_____Zip:_____
Spouse's Name:_____ DOB____/____/____
Employer:_____ Phone:( )_____-_____
Primary Care Physician: _____Referred By:_____

*****RESPONSIBLE PARTY INFROMATION(IF DIFFERENT FROM PATIENT INFORMATION)*****

Full Name:_____Male:_____Female:_____
Address:_____City:_____State:_____Zip:_____
Home Phone:( )_____Work Phone:( )_____Cell Phone:( )_____
DOB____/____/_____SS#_____-_____-_____ Employer_____ Phone( )____-_____

**********INSURANCE INFORMATION**********

Primary Insurance:_____Policy Holder:_____

DOB:___/___/_____ Relationship:_____Employer:_____

Insurance ID#:_____Group #:_____

Secondary Insurance:_____Policy Holder:_____
DOB:___/___/_____ Relationship:_____Employer:_____
Insurance ID#:_____Group #:_____

I understand that I am financially responsible for all charges whether or not it is paid by my insurance. I hereby authorize the Doctor to release medical information to my insurance company to secure payment of benefits. I also authorize the use of signature on all insurance submissions and as authorization for payments to be sent to: John Conner MD. This signature authorizes release of medical records to any physician or healthcare facility then referred or requested by them for continuity of care. *Dr. Conner is an investor of Physicians Medical Center*HB 1273 an Out of Network provider may be called upon to render healthcare items or services to the covered individual during the course of treatment, the out of network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individuals health plan, the covered individual may contact the health plan before receiving healthcare items or services rendered by the out of network provider to obtain a list of network providers that may render the healthcare items or services or for additional services. *You agree, in order for us to service out account/collect any amounts you may owe, we may contact you by telephone, wireless telephone, text message, e-mail that you may have provided to us, this may result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the lender/creditor may contact me/us as described above.

Responsible Party
Signature:_____Relationship:_____Date:_____