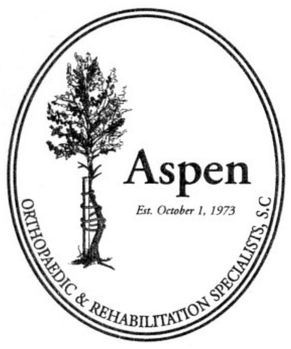

Aspen Orthopaedic & Rehabilitation Specialists, S.C.

2424 S. 90TH ST.
SUITE 500
WEST ALLIS, WI 53227
414-328-8600

19475 W. NORTH AVE.
SUITE 201
BROOKFIELD, WI 53045
262-780-4400

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LEE M. TYNE, M.D.
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JEFFREY E. LARSON, M.D.
RYAN J. KEHOE, M.D.
SEAN E. WILSON, D.P.M.
ROBBY A. AMIOT, D.P.M.

PATIENT INFORMATION (PLEASE PRINT)

PATIENT NAME LAST	FIRST	MIDDLE INITIAL	HOME PHONE	WORK PHONE	CELL PHONE
STREET ADDRESS			DATE OF BIRTH / AGE	SOCIAL SECURITY #:	
CITY	STATE	ZIP CODE	DRIVER'S LICENSE #:		
SEX: M F / MARITAL STATUS: S M W D	EMPLOYER		EMPLOYER ADDRESS		
PERSONAL PHYSICIAN: (FIRST & LAST NAME)			PATIENT OCCUPATION		
ADDRESS					
CITY	STATE	ZIP CODE	PHONE NUMBER		

HAVE YOU BEEN SEEN IN OUR OFFICE BY ANY OF OUR PHYSICIAN'S PREVIOUSLY? ☐ YES ☐ NO

IF YES, WHICH PHYSICIAN? (PLEASE NAME):

WHO REFERRED YOU TO OUR OFFICE (PLEASE ✔ ONE)

☐ YELLOW PAGES ☐ INSURANCE DIRECTORY ☐ WEB SITE ☐ SELF ☐ FAMILY / FRIEND ☐ EMERGENCY ROOM ☐ HEALTH FAIR

☐ OTHER (PLEASE LIST):

☐ PHYSICIAN (PLEASE NAME) FIRST & LAST NAME:

NAME OF EMERGENCY CONTACT / ALTERNATE PHONE # (OTHER THAN YOUR #): HOME PHONE

INSURANCE INFORMATION

IF YOU ARE UNDER 18 YEARS OF AGE, WHO IS THE RESPONSIBLE PARTY?

NAME			
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE		
RELATIONSHIP TO THE PATIENT:			

PRIMARY INSURANCE: ☐ MEDICAL INSURANCE ☐ MEDICARE ☐ SELF-PAY ☐ WORK COMP ☐ LEGAL

INSURANCE COMPANY NAME	
NAME OF POLICY HOLDER	
POLICY HOLDERS SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH
PATIENTS RELATIONSHIP TO POLICYHOLDER	POLICY HOLDERS EMPLOYER

SECONDARY INSURANCE: ☐ MEDICAL INSURANCE ☐ MEDICARE ☐ SELF-PAY ☐ WORK COMP ☐ LEGAL

INSURANCE COMPANY NAME	
NAME OF POLICY HOLDER	
POLICY HOLDERS SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH
PATIENTS RELATIONSHIP TO POLICYHOLDER	POLICY HOLDERS EMPLOYER

PROFESSIONAL FEES: Fees for professional services are based on our own experience and not on payment schedules promoted by insurance companies as usual and customary, average, median, etc., except for prepaid plans with which we have contracted. In many cases the entire fee will be paid by an insurance company while in other cases an insurance company will pay only a portion of the fee. We will furnish a reasonable number of medical and disability insurance reports to expedite your insurance claims. Services must be paid for when rendered unless other advance arrangements have been made.

FINANCIAL AGREEMENT: I hereby authorize payment of medical insurance benefits due me to be made directly to Aspen Orthopaedic & Rehabilitation Specialists, S.C. I understand that I am responsible for that portion of fees not paid by insurance and that a balance over 60 days old will be considered past due. There will be a charge for checks returned for non-sufficient funds. Should the account be referred to an attorney or agency for collection, I will be responsible for reasonable attorney's fees, collection expenses and interest.

DATE _____

SIGNATURE OF: ☐ PATIENT ☐ PARENT OR ☐ GUARDIAN

_____