WILLIAM K. MONTGOMERY, M.D. P.A.

Date of visit: ____

PATIENT NAME: ____

Male (   )   Female (   )   Date of Birth: ______________________   Age: __________________________

Height:____   Weight: ___________________________

If you are having a problem, what is the main complaint you are having:

____

____

____

____

____

Have you seen any other physician for this problem?

____

____

Physician's notes:

Who is your primary care physician and what is the address, phone number and specialty?

Name: ____ Specialty: ______________________________

Address: ____Phone #: ______________________________

City: _____________________________________ State: ___________________ Zip: ______________________

How did you hear about us?

____

____

If you were referred by another doctor, what is the name, phone number and specialty?

Name: ____ Specialty: ______________________________

Address: ____Phone #: ______________________________

City: _____________________________________ State: ___________________ Zip: ______________________

Please list any drug allergies you may have and the side effects of taking them:

____

____

PLEASE PRINT — **PATIENT INFORMATION** (The Person Seeing the Physician)

PATIENT'S NAME - Last, First, Middle Initial	Email Address	Age	Birthdate / /

ADDRESS - Number and Street	City	State	Zip

Sex: ☐ Male ☐ Female	Marital Status: ☐ M - Married ☐ S - Single ☐ D - Divorced ☐ W - Widow/Widower	Spouse's Name	Patient's Driver's License No.

Occupation or Student	Patient's Social Security No.	Home Phone (include area code) ( )	Business Phone (include area code) ( )

Employer Name	Employer Address	City	State	Zip

IMPORTANT → **DO YOU HAVE ANY ALLERGIES?** ☐ NOT KNOWN ☐ NO ☐ YES What Kind?

Patient's Personal Physician or Primary Care Physician (PCP)	Referring Physician	Referred By

☐ ***Same as above*** — **RESPONSIBLE PARTY INFORMATION** (The Person Who Is Financially Responsible)

RESPONSIBLE PARTY NAME - Last, First, Middle Initial	Address - Number and Street

City	State	Zip	Home Phone (include area code) ( )
Resp. Party Social Security No.	**Driver's License No.**	**Employer**	**Business Phone (include area code)** ( )

EMERGENCY CONTACT

NAME - Last, First, Middle Initial	Relationship	Address - Number and Street

City	State	Zip	Home Phone (include area code) ( )

INSURANCE INFORMATION (Please Present Insurance Card to Receptionist)

Do **NOT** indicate your Worker's Compensation Insurance Carrier here. This must be verified by your employer prior to seeing the Physician.

Type: ☐ Medicare ☐ Insurance Plan:	Subscriber's Name (The person who has the policy)	Subcriber's Social Security No.
Insurance Company Name	**Insurance Co. Phone No.** (include area code)	**SUBSCRIBER DATE OF BIRTH**
Insurance Company Address	**Policy No.**	**Group No.**
Employer, If Group Coverage		
Patient's Relationship to Subscriber: ☐ S - Self ☐ W - Wife ☐ H - Husband ☐ C - Child ☐ O - Other	**METHOD OF PAYMENT:** ☐ CASH ☐ CHECK ☐ DEBIT CARD ☐ CREDIT CARD	

Please read before signing - **Assignment of Benefits, Medical Release, and Statement of Financial Responsibility**

I authorize Plano Orthopedic Sports Medicine & Spine Center, P.A. to release medical information and/or records that may be necessary to request reimbursement from (including but not limited to): insurance companies, HMO's, PPO's, Managed Care Contracting agencies, contracted Independent Physician Associations (IPA's), Texas Department of Insurance Division of Workers Compensation, if injury is work related, Third Party Review organizations contracted by an insurance company to review insurance claims, and/or insurance adjusters, to whom a claim has been submitted. I also give my authorization to have medical records mailed, delivered or FAXed to my Primary Care Physician (PCP), "Gatekeeper" or any other physician responsible for my medical care under a managed care contract (if applicable). I also give my authorization to have my medical record mailed, delivered or FAXed to a consulting physician who may review my medical treatment plan with my Plano Orthopedic Physician. I assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to the physician's Professional Associations of: Drs. Sutker, Barber, Smith, Lund, Troop, Courtney, Crates, Dauber, Carmody, Chaim, Montgomery et al. In the event that I receive a payment from my insurance carrier where my physician has filed the claim on my behalf, I will forward that payment to my physician to have it applied to my account. I understand that an insurance claim will be filed with my primary insurance carrier only (Plano Orthopedic will not file on "Secondary" insurance). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges (for non-work related injuries) whether or not paid by said insurance (less any mandated or contractual adjustments). I understand and agree that I am responsible for responding promptly to my insurance company if they request any additional information or accident report and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred. I understand that any overpayment on my account will be promptly refunded. If an account is established, I authorize Plano Orthopedic Sports Medicine & Spine Center, P.A., to obtain a credit report when necessary in regards to my account. Payments by insurance plans on my account must be made within 60 days of filing, and any co-pay or deductible amounts remaining are due by the responsible party and must be paid in full within 30 days after insurance has paid, or there may be a late fee assessed against my account of 1.5% each month on the unpaid balance. I understand that this form must be updated at least annually, may be updated at each visit, and that I will provide Plano Orthopedic with any changes of address or insurance coverage immediately. Failure to notify Plano Orthopedic of any insurance plan changes, could result in loss of insurance benefits and could make me liable for medical charges. Proof of identity is required (e.g., drivers license) for each patient and/or responsible party. I understand that I need to present my insurance card at each visit, and understand that I may be required by my insurance plan to pay my co-payment at each visit. My email address will be used to notify me of appointments or other medical related issues and will not be sold or delivered to any other entity.

SIGNATURE OF RESPONSIBLE PARTY ______________________________ **DATE** ____________

SIGNED BY ______________________________ **RELATIONSHIP TO PATIENT IF MINOR:** ☐ PARENT ☐ GUARDIAN
(NAME PRINTED)