CORY J. LAMBLIN, M.D.

FREMONT ORTHOPAEDICS PC

BEN S. FRANCISCO, M.D.

815 East Main Street ■ Lander, WY 82520

Patient's Name: _____ (Last / First / Middle) Birth Date: _____ Age: _____ (Male/Female) (Circle One)

Marital Status: _____ / _____ (Maiden Name) Home Phone #: _____ Work Phone #: _____

Mailing Address: _____ (Town) (State) (Zip Code) Cell Phone #: _____

Street Address: (If different) _____ (Number & Street or Post Office Box #) (Town) (State) (Zip Code) SS #: _____ (Patient's)

Email Address: _____

Race: White, American Indian or Alaska Native, Black or African American, Asian, Native Hawaiian or other Pacific Islander. (Circle One)

Ethnicity: Hispanic or Latino, Not Hispanic or Latino. (Circle One) Language _____

Patient's Employer: _____ (Name and Address)

Occupation: _____ (Name and Address) Student: _____ Full Time: _____ Part Time: _____

Parent/Spouse Name: _____ SS #: _____

Parent/Spouse Employer: _____ Work Phone #: _____

Emergency Contact (Outside of your household) Name: _____ Home Phone #: _____

List Any Medication Allergies: _____ Are You Diabetic? YES NO

Name of Pharmacy: _____ Referred By: _____

DATE OF INJURY: _____ HOW DID THE INJURY TAKE PLACE?: _____

WHERE: _____

WORK _____ HOME _____ AUTO _____ OTHER _____ BODY PART _____ L R

If Workers' Compensation, please complete:

Have You Filed A Workers' Compensation Report (YES / NO)

Date of Injury: _____ Employer: _____

WC Case #: _____ Employer's Address: _____

County Where Injury Occurred: _____ Other Doctors Seen For Same Accident: _____

INSURANCE INFORMATION:

Medicare #: _____

1st Insurance Name: _____ Medicaid (T-19) #: _____

Address: _____ 2nd Insurance Name: _____

City: _____ State: _____ Zip: _____ Address: _____

_____ City: _____ State: _____ Zip: _____

Insured Name Insured DOB

_____ _____

((Policy #) (Group #)

_____ _____

Insured Name Insured DOB

_____ _____

((Policy #) (Group #)

Method of Payment: ( ) CASH ( ) PERSONAL CHECK ( ) MasterCard/VISA

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: Fremont Orthopaedics, P.C.

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A Copy of this assignment is as valid as the original.)

By signing below, I authorize payment of medical benefits to Fremont Orthopaedics, P.C. for medical services rendered.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

Signature _____ Date _____

(Responsible Party)