PROSPORT ORTHOPAEDICS

James R. Dettling, MD

Gender Male ☐ Female ☐

Patient's Name ______________________________ Date of Birth____/____/____ Age______
Last First Initial

Street Address ______________________________ City __________ State _____ Zip Code _________

Mailing Address ______________________________ City __________ State _____ Zip Code _________

Phone ( ) _______-_______ Work Phone ( ) ______-______ Social Security _________-_______-_________

Driver License Number ____________________ Issuing State _______ Married ☐ Single ☐ Widowed ☐ Divorced ☐

Patient's Employer ____________________ Occupation ____________________ How Long _________

Employer Address ______________________________ City __________ State _____ Zip Code _________

Parent/Spouse Information

Name ______________________________ Relationship __________ Date of Birth _____/_____/_____

Address ______________________________ City__________ State_____ Zip Code _________

Social Security _____-____-_____ Employer____________________ Employer Phone ( ) ______-_______

Emergency Contact
Name/Address/Phone ______________________________ Relationship ___________

Accident? Yes ☐ No ☐ **Work Related?** Yes ☐ No ☐ **Date of Injury** ___/___/___ **Location** ____________

Body Part Affected ____________________ Right ☐ Left ☐ **X-rays With You?** Yes ☐ No ☐

Referred by:____________________ **If seen in ER, when and where:**____________________

Primary Insurance Patient's Relationship to the Subscriber? Self ☐ Spouse ☐ Child ☐ Other ☐

Carrier Name ____________________ Phone ( ) _______-_______ PPO HMO EPO W/C PVT

Address ______________________________ City _________ State _____ Zip Code _________

Subscriber Id Number ____________________ Group Number ____________________

Secondary Insurance Patient's Relationship to the Subscriber? Self ☐ Spouse ☐ Child ☐ Other ☐

Carrier Name ____________________ Phone ( ) _______-_______ PPO HMO EPO W/C PVT

Address ______________________________ City _________ State _____ Zip Code _________

Subscriber Id Number ____________________ Group Number ____________________

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Date

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Signature of patient or person acting on behalf of patient