CENTENNIAL ORTHOPEDICS
A Division of Mercy Medical Center

Patient's Name _____ ☐ Male ☐ Female
Last First Middle Int.

Mailing Address _____
Box/Street City State Zip

Street Address _____
Street City State Zip

Date of Birth _____ SS# _____ Marital Status S / M / D / W / Other

Email Address: _____

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hawaiian or Other Pacific Islander ☐ Chinese ☐ Filipino ☐ Japanese ☐ Multi Racial

Language: ☐ English ☐ Spanish ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Home Phone _____ Cell _____ May we contact you at work? ☐ Yes ☐ No

May we leave a message? ☐ Yes ☐ No If so, what Phone Number? _____

Primary Care Provider _____

Emergency Contact _____ Phone _____

RESPONSIBLE PARTY for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law _____

Name _____ Responsible Party's Phone _____

Mailing Address _____
Box/Street City State Zip

Employer _____ Work Phone _____ Ext _____

Additional Guardian Information _____ Cell Phone _____

PRIMARY INSURANCE for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law _____

Insured / Employee's Name _____
Last First Middle Int.

Insurance Name _____ Group Name / Employer _____

Group # _____ Policy ID # _____ Effective Date _____

Insured's Date of Birth _____ Insured's SS# _____

SECONDARY INSURANCE for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law_____

Insured / Employee's Name _____
Last First Middle Int.

Insurance Name _____ Group Name / Employer _____

Group #_____ Policy ID #_____ Effective Date _____

Insured's Date of Birth _____ Insured's SS# _____

ADDITIONAL INFORMATION

Please provide a list of all the parties we may speak with or leave a message with regarding the patient's medical care, appointment scheduling, or payment information.

Name Relationship	Name Relationship
Name Relationship	Name Relationship

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Centennial Medical Group to render needed treatment to the above named patient.
2. I authorize Centennial Medical Group to release needed treatment to the above named patient.
3. I authorize payment of medical benefits to Centennial Medical Group, for services rendered.
4. I understand that I am responsible for all charges incurred through Centennial Medical Group.
5. Authorization Period: From _____ to _____ OR Lifetime

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect Collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

Signature _____ Date _____

CMG CENTENNIAL ORTHOPEDICS
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