Plancher Orthopaedics & Sports Medicine, PLLC
Demographic Update

PATIENT INFORMATION ***DATE*: _____**

First Name: _____ M: _____
Last Name: _____
Address: _____
City, State, Zip: _____
Phone 1: _____ □ Home □ Work □ Mobile
Phone 2: _____ □ Home □ Work □ Mobile
Phone 3: _____ □ Home □ Work □ Mobile

SSN#: _____ Gender: □ M □ F
DOB: _____/_____/_____ Age: _____
Marital Status: □ Married □ Single □ Divorced □ Widowed
Race/Ethnicity: _____
Primary Language: _____
Email Address: _____
Height: _____ Weight: _____ Dominant Hand: _____

Patient Employment Information
□ Employed □ Retired □ Student
Occupation: _____
Employer: _____
Phone: _____
Address: _____
City, State, Zip: _____

Primary Care Physician
Name: _____
Phone: _____
Address: _____
City, State, Zip: _____
Were you referred to us by this doctor? □ Yes □ No

Pharmacy Information
Primary Pharmacy: _____
Phone: _____
Address: _____
City, State, Zip: _____

Emergency Contact
Name: _____
Phone: _____
Address: _____
Relationship: _____

INSURANCE INFORMATION

Primary Insurance
Insurance Carrier: _____
Insured ID: _____
Policy Group #: _____
Policy Holder: _____
□ Self □ Spouse □ Parent □ Partner
DOB: _____/_____/_____ SSN#: _____

Secondary Insurance
Insurance Carrier: _____
Insured ID: _____
Policy Group #: _____
Policy Holder: _____
□ Self □ Spouse □ Parent □ Partner
DOB: _____/_____/_____ SSN#: _____

Did you sustain this injury at work? □ Yes □ No
(If no, you may skip this section. If yes, the information below is mandatory prior to seeing your doctor)

Worker's Compensation Information
Insurance Carrier: _____
Billing Address: _____
City, State, Zip: _____
Claim Number: _____
Employer (at time of injury): _____
Attorney (if applicable): _____

Date of Injury: _____
Body Part(s): _____
Claims Adjuster: _____
Adjuster Phone: _____
Adjuster Fax: _____
Location of Injury: City: _____ State: _____

Are your injuries car accident related? □ Yes □ No
(If no, please continue with the rest of the packet. If yes, please inform the front desk)