



Patient Account Number: \_\_\_\_\_ Date: \_\_\_\_\_  
(Office Use Only)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ SSN# \_\_\_\_\_

Email Address: \_\_\_\_\_

Yes, Panorama may contact me about important information on appointments, billing, patient education and more!

Male / Female Employer: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing address if different from above: \_\_\_\_\_ SSN# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing address if different from above: \_\_\_\_\_ SSN# \_\_\_\_\_

Patient Relationship to Policy Holder:  Self  Spouse  Child  Other: \_\_\_\_\_

**Please complete this section if the patient is a minor**

Responsible Party Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ SSN#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_

**Emergency Contact**

In case of emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Insurance Authorization and Assignment of Benefits:**

I authorize the physicians and physicians' assistants at Panorama Orthopedics and Spine Center to treat my illness or injury. I hereby authorize the release of any medical information necessary to process my claim and I authorize payment of medical and surgical benefits to Panorama Orthopedics and Spine Center.

"The following physicians have an ownership interest in the Golden Ridge Surgery Center: Amit Agarwala, M.D.; Mitchell Seemann, M.D.; Christopher Brian, M.D.; Mark Conklin, M.D.; Bharat Desai, M.D.; Douglas Foulk, M.D.; Thomas Frierwood, M.D.; Charles Gottlob, M.D.; James Johnson, M.D.; Patrick McNair, M.D.; Peter Lammens, M.D.; Mark Mills, M.D.; Thomas Puschak, M.D.; Walter Robinson, M.D.; Eric Stahl, M.D.; Douglas Strahley, M.D.; Douglas Wong, M.D."

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If patient is a minor, parent/legal guardian must sign of their behalf)

Relationship to Patient: \_\_\_\_\_