2908 E. 26th Street ◆ Sioux Falls, SD 57103

Appointment Date ____________ Time _________

Chart ______________________________

Account ______________________________

Gregory F. Alvine, M.D. Jeffrey S. Kalo, D.O. David Watts, M.D. Erik Peterson, M.D. Jonathan Blake, D.O. Travis Venner, D.P.M.
Brett Bastian, PA-C Angela Majeres, PA-C Ryan Klenner, PA-C Mary Fiedler, CNP Jill Johannsen, D.P.T.

Patient Name (please print) ____________________
Maiden

____
First Middle In. Last

Address ______________________________

City ____________________ State ____ Zip ________

Social Sec. # ______________________________

Cell Phone ______________________________

Home Phone ______________________________

Date of Birth ______________ Gender ______ Age _____

E-mail ______________________________

Employer ______________________________

Address ______________________________

City ____________________ State ____ Zip ________

Work Phone ______________________________

Parent or Guardian Name if Under 18 years of age:

______________________ Work/Cell # ____________

Why are you seeing the doctor today? ____________________

____

Current problem is the result of a:

❑ Motor Vehicle Accident ❑ Work Related Injury

❑ Liability ❑ Other

Date of Injury ______________________________

State in which injury occurred ____________________

Name of Person **"not living with you"** to contact in case of emergency:

____

Work Phone ______________________________

Hm/Cell Phone ____________ / ____________

Address ______________________________

City ________________ State ____ Zip _______

Complete if Married

Name of Spouse ________________ DOB ______

Work/Cell Phone ____________ / ____________

Employer ______________________________

Address ______________________________

City ________________ State ____ Zip _______

Family Doctor ______________________________

Referring Physician ______________________________

How did you hear about us? ____________________

____

Authorization to pay CORE Orthopedics Avera Medical Group

X ______________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________________, have received the Notice of Privacy Practices from CORE Orthopedics Avera Medical Group.

X ______________________________________ Date ______________

In lieu of patient signature, I, ____________________________, a staff member at CORE Orthopedics Avera Medical Group, state that ____________________________ has been given our current Notice of Privacy Practices.

X ______________________________________ Date ______________

PLEASE COMPLETE AND RETURN

❑ **MEDICARE #**________________________	❑ **MEDICAID #**__________________ *State*____
❑ **PRIMARY INSURANCE:**	❑ **SECONDARY INSURANCE:**
Name of Insurance Company: ________________________	Name of Insurance Company: ________________________
Address of Insurance Company: ________________________	Address of Insurance Company: ________________________
City __________________ State____ Zip________	City __________________ State____ Zip________
POLICYHOLDER DOB: ____________________	POLICYHOLDER DOB: ____________________
Name of Policyholder:______________________	Name of Policyholder:______________________
Policyholder Social Sec. # ________ /_____ /________	Policyholder Social Sec. # ________ /_____ /________
Patient Relationship to Policyholder:	Patient Relationship to Policyholder:
❑ Self ❑ Spouse ❑ Child	❑ Self ❑ Spouse ❑ Child
❑ Other - Please Define ____________________	❑ Other - Please Define ____________________
Policy Number of INSURED: ________________________	Policy Number of INSURED: ________________________
Group NAME: ________________________	Group NAME: ________________________
Group NUMBER: ________________________	Group NUMBER: ________________________
Does your Insurance Company Require Pre-authorization?	Does your Insurance Company Require Pre-authorization?
❑ YES ❑ NO	❑ YES ❑ NO

FINANCIAL AGREEMENT:

I understand that I am financially responsible for all charges not covered by insurance. In the event that there is a balance unpaid by insurance. I guarantee the balance be paid:

❑ Cash ❑ Check ❑ CC/Debit Card #_____ ______ ______ ______ exp:___ ___

I understand any balance is considered delinquent after 90 days:

X ____ Date ________________

PRE-AUTHORIZATION

Our office will pre-authorize surgeries; however, pre-authorization does not guarantee payment. Questions regarding payment or benefits should be directed to your insurance carrier.

If your insurance company requires that you go to a specific hospital or facility in order to receive benefits for surgery, tests, or therapy, it is your responsibility to let us know.

Guidelines when calling your insurance company:

Is pre-authorization required?

Is a second opinion required?

Are you in a waiting period for pre-existing conditions?

X____ Date ________________