Bear Lake Orthopeadics **PLEASE COMPLETE 4 PAGES**
Kerry G. Jepsen, M.D.

❖ Patient Information

Name (Last, First, Middle)	Employer of Guarantor
Local Address	Employer Address
City, State, Zip	City, State, Zip
Home Phone	Work Phone
Cell Phone	Emergency Contact
Social Security #	Address
Birth date	City, State, Zip
Sex Male Female	Phone

❖ Responsible Party Information (if Different than above)

Name (Last, First, Middle)	SSN	Birthdate	Sex
Local Address	Secondary/Billing (if Applicable)		
City, State, Zip	City, State, Zip		
Home Phone	Home Phone		
Relation To Patient			

❖ Primary Insurance

Name of Insurance Company	Policy #	
Name of Insured	Group #	
Insured SS #	CoPay amount $	
Insured Date of birth	Deductible $	
Relationship to Patient	Effective Date	Expiration Date

❖ Secondary Insurance (if Applicable)

Name of Insurance Company	Policy #	
Name of Insured	Group #	
Insured SS #	CoPay amount $	
Insured Date of Birth	Deductible $	
Relationship to Patient	Effective Date	Expiration Date

Pharmacy _____Referred by _____ Date of Injury_____

Worker's Comp Case? YES / NO Workman's Comp Case #_____

I hereby assign all medical and/or surgical benefits to Bear Lake Orthopeadics. A photo copy of this is to be considered original. I understand that I am financially responsible for all charges. I hereby authorize said assignee to release all information necessary to secure payment.

_____ _____

Signature of Patient/Guardian Date