

CHAMPLAIN VALLEY ORTHOPEDICS, PC  
ORTHOPEDIC SURGERY & SPORTS MEDICINE  
(802) 388-3194  
www.champlainvalleyortho.com

**PATIENT INFORMATION**

NAME \_\_\_\_\_  
First Middle Last Nickname  
HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
PRIMARY CARE PHYSICIAN \_\_\_\_\_ SS# \_\_\_\_\_  
DATE OF INJURY /ONSET \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

**EMPLOYMENT INFORMATION**

OCCUPATION \_\_\_\_\_ EMPLOYER (OR) PARENT'S EMPLOYER \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ WORK ADDRESS \_\_\_\_\_

**MEDICAL RECORDS INFORMATION RELEASE**

I GIVE CHAMPLAIN VALLEY ORTHOPEDICS PERMISSION TO SPEAK WITH THE PERSON LISTED BELOW REGARDING MY HEALTHCARE.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE NO. \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

ADDRESS \_\_\_\_\_  
\*\*\* MUST HAVE POLICY HOLDERS NAME AND DATE OF BIRTH  
NAME OF POLICY HOLDER \_\_\_\_\_  
POLICY HOLDERS D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ SS # \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
CO-PAY AMOUNT \_\_\_\_\_

POLICY NO. \_\_\_\_\_  
GROUP NO. \_\_\_\_\_  
RELATION TO PATIENT \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
WORK ADDRESS \_\_\_\_\_

**SECONDARY INSURANCE**

ADDRESS \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_  
POLICY HOLDERS D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

POLICY NO. \_\_\_\_\_  
GROUP NO. \_\_\_\_\_  
RELATION TO PATIENT \_\_\_\_\_

**WORKMAN'S COMPENSATION (OR) AUTO ACCIDENT INFORMATION ONLY**

IS THIS INJURY WORK RELATED? YES \_\_\_\_\_ NO \_\_\_\_\_  
WORKMAN'S COMP CLAIM NO. \_\_\_\_\_  
INSURANCE CARRIER OF WORKMAN'S  
COMP CLAIM \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE \_\_\_\_\_  
PERSON TO CONTACT REGARDING  
THIS CLAIM \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_  
HAS AN ATTORNEY BEEN RETAINED? YES \_\_\_\_\_ NO \_\_\_\_\_  
ATTORNEY'S ADDRESS \_\_\_\_\_

AUTO ACCIDENT? YES \_\_\_\_\_ NO \_\_\_\_\_  
INSURANCE COMPANY COVERING  
THIS ACCIDENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE \_\_\_\_\_  
PERSON TO CONTACT REGARDING  
THIS CLAIM \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_  
NAME OF ATTORNEY \_\_\_\_\_  
PHONE NO. \_\_\_\_\_

I HEREBY AUTHORIZE CHAMPLAIN VALLEY ORTHOPEDICS, PC TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION REQUESTED BY THEM AS WELL AS DIRECT PAYMENT OF INSURANCE BENEFITS TO CHAMPLAIN VALLEY ORTHOPEDICS, 1436 EXCHANGE STREET MIDDLEBURY, VERMONT 05753

SIGNATURE OF PATIENT \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF PARENT (OR) GUARDIAN IF PATIENT IS A MINOR \_\_\_\_\_