M. Christopher MacLaren, D.O., FAOAO
Board Certified, Diplomat and Fellow AOAO
Orthopaedic Surgery and Sports Medicine

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Board Certified Orthopaedics Surgeons
Fellow American Academy Orthopaedic urgeons

813-855-8450 – Fax 813-855-6320

Patient Information

Today's Date _____Home Phone _____

Name _____ SS# _____

Address _____Cell Phone _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Married ☐ Widow ☐ Single ☐ Divorced/Separated ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____

Emergency Contact _____ Phone _____

Family/Referring Dr _____Phone _____Fax _____

Primary Insurance **please give receptionist your photo ID and insurance cards**

Insured Name _____ DOB _____

Address if different then above _____ Phone _____

City _____ State _____ Zip _____ SS# _____

Insured Employer _____ Wk Phone _____

Insurance Company _____

Subscriber ID # _____ Group # _____

Insurance Address _____ Phone _____

City _____ State _____ Zip _____ Fax# _____

Do you have secondary Insurance? ☐ Yes ☐ No Insurance Company _____

Workers Compensation or MVA information

Claim Number _____ Date of Injury _____

WC MVA Company Name _____ Phone _____

Address for Claims _____

Adjuster Name _____Phone _____Fax _____

Nurse Case Manager _____Phone _____Fax _____

Attorney Name _____Phone_____Fax _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MacLaren Sports Medicine Inc. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date