Capital City Orthopaedics, P.A.
Michael W. Burris, M.D.

Welcome To Our Office!

Name: _____
First Middle Last
Home Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: (_____) _____ Alt. Phone: (_____) _____
Email Address: _____

Employer: _____ Work Phone: (_____) _____
SSN: _____ Birthdate: _____

Emergency Contact: _____ Relationship: _____
Phone: (_____) _____ Work Phone: (_____) _____
Primary Insurance Carrier: _____ Policy Number: _____
Secondary Insurance Carrier: _____ Policy Number: _____
Pharmacy & Address: _____

Complete below only if someone other than the patient is financially responsible for the patient's medical care.

Responsible Party: _____ Relationship: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: (_____) _____ Cell Phone: (_____) _____
Employer: _____ Work Phone: (_____) _____
SSN: _____ Birthdate: _____

Our office will file insurance claims on your behalf for all reimbursable services, to both your primary and secondary insurance carriers. By signing below, you agree to the following:

1) Your insurance company will make payment of benefits to Capital City Orthopaedics.
2) We may release your medical data to other organizations as required to adjudicate your insurance claims.
3) Capital City Orthopaedics may view your external prescription data as needed to provide medical care.
4) You are responsible for all deductibles, co-pays, and non-covered service amounts. See our financial policy for additional details.

_____ _____
Signature of Patient or Responsible Party Date