



Orthopedic Surgery

8100 Timberlake Way Suite F ♦ Sacramento, Ca 95823

Phone (916) 689-7370 ♦ Fax (916) 688-5610

Stephen M. Howell, M.D.

www.drstevehowell.com

~ Patient Information ~

Last Name _____ First Name _____ M.I. _____ DOB ____/____/____

Home Phone # (____) _____ Cell Phone # (____) _____

Address _____

City _____ State _____ Zip Code _____

Sex M F Social Security # _____ - _____ - _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Phone # (____) _____ Who Referred You? _____

E-Mail Address _____

Primary Care Physician _____ Phone # (____) _____

In case of an emergency who should be notified? _____ Phone # (____) _____

Are you here for a work related injury? Yes No What date were you injured on the Job _____

~Responsible Party for Payment~

Last Name _____ First Name _____ M.I. _____ DOB ____/____/____

Home Phone # (____) _____ Social Security # _____ / _____ / _____

Address _____

City _____ State _____ Zip Code _____

Or Same Person as Above

~Insurance Information~

Primary Insurance _____ Policy Holder _____ Relationship to Patient _____

Subscriber # _____ Group # _____ Medical Group _____

Employer _____ Employer Phone # (____) _____

Secondary Insurance _____ Policy Holder _____ Relationship to Patient _____

Subscriber # _____ Group # _____ Medical Group _____

Employer _____ Employer Phone # (____) _____

~Assignment and Release~

I hereby certify that the above information is true to the best of my knowledge. I authorized the physician to release all information necessary to secure payment of services rendered. I hereby authorize my insurance company to issue payment directly to Steven J. Barad, M.D., and or Stephen M. Howell, M.D. I fully understand that I am responsible for any debt incurred for treatment of my dependents or myself. I understand that insurance billing is a courtesy and any problems with my insurance carrier, if billed by my doctor, becomes my responsibility for payment of services.

_____ Relationship _____ Date _____

Responsible Party Signature