

Kern Bone and Joint Specialists, Inc.

(661) 324-2491 • FAX (661) 324-1045

- James B. Grimes, M.D.
- Brian C. Brenner, M.D.
- Firooz Amjadi, M.D.

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

DATE: _____

MALE FEMALE

SOCIAL SECURITY #: _____

NAME _____ DRIVERS LICENSE #: _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BIRTH DATE _____ AGE _____

NEAREST FRIEND OR RELATIVE & PHONE # _____

MARITAL STATUS: Married Single Divorced Separated Widower Widow Minor

EMPLOYED BY _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ WORK PHONE _____

SPOUSE _____ EMPLOYER _____

REASON FOR THIS VISIT: Illness Injury Job Related Auto Accident

DATE OF INJURY OR ONSET OF PROBLEM ____/____/____ MAJOR COMPLAINT: _____

HOW OCCURRED: _____

WHO REFERRED YOU TO THIS OFFICE? _____

PARENT / GUARDIAN INFORMATION (IF PATIENT IS A MINOR)			
FATHER'S NAME:	SS #:	MOTHER'S NAME:	SS #:
ADDRESS:	PHONE:	ADDRESS:	PHONE:
EMPLOYERS NAME:		EMPLOYERS NAME:	
ADDRESS:		ADDRESS:	
OCCUPATION:	PHONE:	OCCUPATION:	PHONE:

▼ MEDICAL INSURANCE INFORMATION

HOW DO YOU INTEND TO PAY: Cash Check Insurance Medicare Medi/Cal

PRIMARY INSURANCE CO.: _____ INSURED: _____ GROUP #: _____

ADDRESS _____ DOB: _____

POLICY NUMBER: _____

2. SECONDARY INSURANCE CO.: _____ INSURED: _____ GROUP #: _____

ADDRESS: _____ DOB: _____

POLICY NUMBER: _____

▼ IF YOUR INJURY IS JOB RELATED

NAME OF INSURANCE COMPANY: _____

ADDRESS OF INSURANCE COMPANY: _____

NAME OF PERSON WHO AUTHORIZED TREATMENT: _____

EMPLOYER AT TIME OF INJURY: _____

INSURANCE CARRIER PHONE NUMBER: () _____

CLAIM NUMBER: _____

▼ PLEASE TURN OVER, SIGN AND RETURN TO RECEPTIONIST