Lucas Rylander, MD
Orthopedic Surgery & Sports Medicine

Demographics/Intake

Today's Date _____ General Reason for Visit _____ Last Name _____ First Name _____ Middle Initial _____ Street Address _____ Apartment _____ City _____ State _____ Zip Code _____

Home Telephone _____ Male Female Marital Status: S M D W SEP Date of Birth _____ Age _____ Social Security Number _____ Cell Phone / Pager _____ Email Address _____ Emergency Telephone _____ Name / Relationship _____ Employer _____ Occupation _____ Work Address _____ Work Telephone _____

Primary Insurance Information

Name of Insurance Company _____ Telephone Number _____ Billing Address _____ City _____ State _____ Zip Code _____ Name of Insured _____ Relationship to Patient _____ Policy Number _____ Group Number _____ Social Security Number of Insured _____ Date of Birth of Insured _____

Secondary Insurance Information (if applicable)

Name of Insurance Company _____ Telephone Number _____ Name of Insured _____ Relationship to Patient _____ Policy Number _____ Group Number _____ Social Security Number of Insured _____ Date of Birth of Insured _____

Referring/Primary Care Physician Information

Referring Physician _____ Telephone Number _____ Street Address _____ City _____ State _____ Zip Code _____ Primary Care Physician (if other than

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Referring Physician) _____ Primary Care Physician
Telephone Number _____

How did you hear about us?
_____

I hereby authorize the doctor indicated above or his personnel to furnish any and all records, medical history, services rendered or treatment given to me or my dependents for purposes of review and evaluation for claims submitted to my insurance carrier.

I also authorize medical benefits to be paid on my behalf directly to the doctor's office for any services furnished by the doctor to me or my dependents.

Signature of Patient (or Guardian if Patient is Under 18 Years Old)