ORTHOPEDIC ASSOCIATES OF DAYTON

Patient Disability/Insurance Form Request

Patient Name: _____ Date of Birth _____

Phone Number: _____

Physician: _____ Procedure Date: _____

Last Work Date: _____ Return to Work Date: _____

Information to Be Mailed To

Name of Person/Company to Receive Information: _____

Mailing Address: _____

Information To Be Faxed To

Name of Person/Company to Receive Information: _____

Fax Number: _____

☐ **Patient will pick up a copy when completed.**

I authorize Orthopedic Associates of Dayton to forward the requested information to the person/company stated above. I also understand that a $10.00 fee per set is required to complete the requested forms at the time of this authorization. To maintain patient care as the highest priority, Orthopedic Associates of Dayton reserves the right to allow 7-10 business days to complete any medical, disability and or insurance forms.

Patient Signature: _____ Date: _____

Date Received: _____ Fee Collected: Yes or No Amount Paid: _____

Employee Initials: _____