



# The Indiana Orthopaedic Center

(317) 588-2663

TOLL FREE: 888-462-3627

Please complete order form and fax with insurance card to **(317) 863-2198.**

### Check Preferred Physician. If no preference, please leave blank:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Eric S. Leaming, M.D.    | <input type="checkbox"/> Ralph H. Kahn, M.D.   | <input type="checkbox"/> Brett R. Fink, M.D.    |
| <input type="checkbox"/> Richard W. Eaton, M.D.   | <input type="checkbox"/> Jon M. Sieber, M.D.   | <input type="checkbox"/> Gregory L. Estes, M.D. |
| <input type="checkbox"/> Douglas A. Kuhn, M.D.    | <input type="checkbox"/> Herbert M. Biel, M.D. | <input type="checkbox"/> Philip C. Sailer, M.D. |
| <input type="checkbox"/> Edward P. Todderud, M.D. | <input type="checkbox"/> C. Melton Doxey, M.D. |   |

### Scheduling Information:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: F M

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

Signs/Symptoms: \_\_\_\_\_

Previous Films within the last year:  X-Ray  MRI  CT  Other \_\_\_\_\_

### Area of Body Requiring Assessment:

Left	Right	Description	Left	Right	Description	Left	Right	Description
<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic Spine
<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Wrist/Hand	<input type="checkbox"/>	<input type="checkbox"/>	Lumbar Spine
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot

### Special Instructions:

Call patient to schedule  Patient will call to schedule  Other \_\_\_\_\_

### Insurance Information:

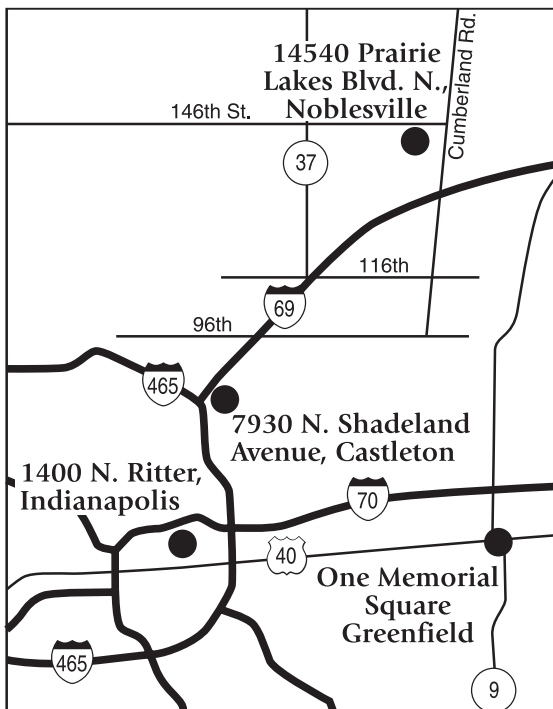
Insurance Information (Please bring all insurance information to appointment)

Authorization Required?  Yes  No If Yes, authorization number \_\_\_\_\_

Work Comp or  Auto: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_



### Specialties:

Hand Surgery, Joint Replacement,  
Spine Surgery, Fracture Care,  
Sports Medicine, Foot/Ankle,  
General Orthopaedic Surgery,  
Rehabilitation & Physical Therapy,  
and Worker's Compensation

### Hospital Affiliations:

Riverview Hospital  
Community Hospital North  
Community Hospital East  
Hancock Regional Hospital  
St. Vincent Hospital

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