2009 PATIENT INFORMATION

Last Name First Name Middle Initial

Sex ☐ M ☐ F Birth Date ____/____/____ Social Security # ____

Street Address ____ City ____ State ____ Zip ____

PHONE: Home ( ) ____ REFERRING MD ____ Phone ( ) ____

Work ( ) ____ Ext. ____ Family M.D./PCP ____ Phone ( ) ____

Cell ( ) ____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status ____ (FULL-TIME, PART-TIME, STUDENT, UNEMPLOYED) Work Related Injury? ☐ Yes ☐ No

Auto Related Injury? ☐ Yes ☐ No

E-Mail: ____ School / Sports Related Injury? ☐ Yes ☐ No ____ SCHOOL NAME

COMPLAINT ____ BODY PART Date of Injury / Onset of Symptoms ____

RESPONSIBLE PARTY (IF PATIENT IS UNDER 18)

Name ____

Relationship to Patient ____

Street Address ____

City, State, Zip ____

Occupation ____

PHONE: Home ( ) ____

Work ( ) ____ Ext. ____

PRIMARY INSURANCE

Insurance Name ____

Subcriber's Name ____

Sex of Subscriber ☐ Male ☐ Female

Date of Birth ____

Social Security # ____ ID # ____

Subscriber's Employer Name ____

Street Address ____

City, State, Zip ____

Phone ____ Ext. ____

EMERGENCY CONTACT Please list the nearest living relative/friend other than your spouse or parent.

Name ____

Relationship ____

Street Address ____

City, State, Zip ____

Occupation ____

PHONE: Home ( ) ____

Work ( ) ____ Ext. ____

SECONDARY INSURANCE

Insurance Name ____

Subcriber's Name ____

Sex of Subscriber ☐ Male ☐ Female

Date of Birth ____

Social Security # ____ ID # ____

Subscriber's Employer ____

Street Address ____

City, State, Zip ____

Phone ____ Ext. ____

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to The Orthopaedic and Sports Medicine Center, its successors and assigns, or any individual it may designate for services provided.

I further agree to pay all costs of collection, including reasonable attorney's fees, associated with collection of any amount due to services rendered and performed. I understand that I am financially responsible to The Orthopaedic & Sports Medicine Center, its successors and assigns and any individual it may designate for any balance not covered by insurance. The assigned will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid original. I hereby authorize said assignee to release all information to secure payment. (All rules and regulations of insurance companies that the OSM participates will apply.)

Signature ____ Date ____

Medicare Authorization

I request that payment of authorized benefits be made either to me or on my behalf to ____ for services furnished to me by the provider. I authorize any holder of medical information about me to the Health Care Financing Authority and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature ____ Date ____

Staff Initials ____

____ Updated ____ Updated ____ Updated ____ Updated