ORTHOPEDIC ASSOCIATES, P.C.

Patient Information: This section refers to the PATIENT ONLY

Account Number:_____

Social Security Number:_____ Employed ____ Retired ____

Last Name:_____ Jr., II, _____ Employer:_____

First Name:_____ Middle Name_____ Address:_____

Maiden Name:_____ Spouse Name:_____ _____

Address:_____ Zip Code:_____

Zip Code:_____ City:_____State: _____ City/State:_____

E-mail Address: _____@_____. _____

Home Phone: (_____)_____ Primary Care Physician:_____

Work Phone: (_____)_____Ext_____ Referring Physician:_____

Birth Date (mm/dd/yy): _____Age_____ If Student ☐ Full-Time ☐ Part-Time

Race: Caucasian Hispanic African-American Other:_____ Sex: ☐ Male ☐ Female
(Note: this information is requested only to help assess clinical risk factors)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Responsible Party: This section refers to the PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Compensation Carrier
_____

Address:
_____

WCB Case #:_____Carrier Case #:
_____

Employer Name & Address at time of injury: (If different from current employer listed above)

Name _____Street
_____

Zip Code:_____ City:_____State:____ Phone: (____)_____

What part of your body was injured?
_____

Date of injury? _____Dates out of work due to problem? _____-____-____to____-_____-_____

Other Medical Insurance: _____ Policy #:
_____

Group#: _____Subscriber:
_____DOB_____

ACCIDENT INFORMATION….

Is your injury a result of a work related accident? Y / N **Date of Accident:**_____

Is your injury a result of an automobile accident? Y / N **Date of Accident:**_____

IN CASE OF EMERGENCY . . . .

Name and Phone number of nearest relative NOT living with you (include relationship):

_____ _____

AUTHORIZATION FOR TREATMENT AND TO PAY BENEFITS TO THE PHYSICIAN . . . .

I attest that this information is true and correct to the best of my knowledge. I confirm that I have received a copy of the Orthopedic Associates, P. C. *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I authorize the office of Orthopedic Associates, P.C., to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept financial responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible, non-covered services and the reasonable cost of collection.

_____ _____

Date **Signature of Patient and / or Guardian, if patient is Minor**