

REFERRING PHYSICIAN: \_\_\_\_\_  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Phone Number \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Phone Number \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT INFORMATION (Please Print)					
NAME (First Name, Last Name, Middle Name)		SOCIAL SECURITY #	DATE OF BIRTH		MALE _____ FEMALE _____
MAILING ADDRESS		CITY	STATE	ZIP	HOME PHONE
EMPLOYER/SCHOOL		OCCUPATION			WORK PHONE
EMPLOYER ADDRESS		CITY	STATE	ZIP	MARITAL STATUS SING. MARR. OTHER
IS CONDITION AUTO RELATED? YES ___ NO ___	IS CONDITION WORK RELATED? YES ___ NO ___	OTHER ACCIDENT (please explain) YES ___ NO ___			
PARENT OR GUARDIAN'S NAME		NEXT OF KIN			PHONE NO.
PREFERRED LANGUAGE	RACE	ETHNICITY			
EMAIL					
EMERGENCY CONTACT					
NAME		RELATIONSHIP		TELEPHONE #	
PRIMARY INSURANCE					
PRIMARY INSURANCE COMPANY NAME		MEMBER ID #		GROUP #	
SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH		MALE ___ FEMALE ___	
MAILING ADDRESS		CITY	STATE	ZIP	HOME PHONE
EMPLOYER		OCCUPATION			WORK PHONE
SECONDARY INSURANCE					
PRIMARY INSURANCE COMPANY NAME		MEMBER ID#		GROUP #	
SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH		MALE ___ FEMALE ___	
I hereby authorize ORTHOPAEDIC SPORTS SPECIALISTS to leave answering machine/voicemail messages or give messages regarding my visit (name of person) _____ either at home or work.					
PATIENT SIGNATURE				DATE	
MEDICARE SIGNATURE					
NAME OF BENEFICIARY				ID #	
I request that payment of the authorized Medicare benefits be made either to me on my behalf or to ORTHOPAEDIC SPORTS SPECIALIST for any services furnished me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, though physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.					
SIGNATURE OF BENEFICIARY				DATE	
ASSIGNMENT OF BENEFITS					
I, _____ hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled to: ORTHOPAEDIC SPORTS SPECIALISTS. This assignment will remain in effect until revoked buy me in writing. I understand that I am financially responsible for all charges whether of not paid by said insurance. I hereby authorize as said assignee to release all information necessary to secure payment of said benefits.					
SIGNATURE		DATE	WITNESS		