



**ORTHOPAEDIC
SPORTS SPECIALISTS**

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.
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				
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 by me in writing. I understand that I am financially responsible for all charges whether or 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	