

RECONSTRUCTIVE ORTHOPEDICS, P.A. Patient information Sheet

TODAY'S DATE ____/____/____

NAME _____ BIRTH DATE ____/____/____ AGE _____ M / F
Last First MI

SOCIAL SECURITY # _____ MARITAL STATUS: M / S / D / W

ADDRESS _____
Street City State ZIP Code

HOME PHONE # (_____) _____ WORK PHONE # (_____) _____

NAME OF PARENT OR GUARDIAN (IF APPLICABLE) _____

IN EMERGENCY, CONTACT - NAME _____ PHONE # (_____) _____

OCCUPATION _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____
STREET CITY STATE ZIP

PRIMARY PHYSICIAN _____ PHYSICIAN'S PHONE # (_____) _____

PRIMARY PHYSICIAN'S ADDRESS _____
STREET CITY STATE ZIP

INSURANCE # 1

NAME OF INSURANCE _____

POLICY OR ID # _____ GROUP # _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER NAME _____ SUBSCRIBER SOC. SEC # _____ SUBSCRIBER DATE OF BIRTH _____

INSURANCE # 2

NAME OF INSURANCE _____

POLICY OR ID # _____ GROUP # _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER NAME _____ SUBSCRIBER SOC. SEC # _____ SUBSCRIBER DATE OF BIRTH _____

MOTOR VEHICLE / WORKER COMPENSATION INFORMATION

WAS **THIS INJURY** DUE TO A **MOTOR VEHICLE ACCIDENT** ? Y N

DATE OF ACCIDENT: _____ PLEASE FILL OUT ATTACHED MOTOR VEHICLE INSURANCE FORM.

WAS **THIS INJURY** DUE TO AN **ACCIDENT AT WORK** ? Y N

DATE OF INJURY _____ PLEASE FILL OUT ATTACHED WORKER'S COMPENSATION FORM.

RECONSTRUCTIVE ORTHOPEDICS, P.A.

ASSIGNMENT OF BENEFITS

I hereby authorize **Reconstructive Orthopedics, PA** to furnish information to the insurance carriers I have listed above concerning all illnesses and treatments. I also hereby authorize copies of my records to be sent to my referring physician and/or my family physician. I hereby irrevocably assign to **Reconstructive Orthopedics, P.A.** all my rights and benefits under any insurance contracts for payment for all services rendered to myself or to my dependent(s) by **Reconstructive Orthopedics, P.A.** I hereby irrevocably authorize all payment for medical services rendered to myself, or my dependent(s), be paid directly to **Reconstructive Orthopedics, P.A.** I understand I am responsible for any amount not covered by insurance including my co-pay. **(If this balance is not paid within 30 days I will be subject to a 1.5% interest charge per month.)**

DATE _____ SIGNATURE _____

MEDICARE AUTHORIZATION FOR PAYMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

DATE _____ SIGNATURE _____