

Eastern Orthopedics and Sports Medicine

2800 Tamarack Dr., Ste 104
South Windsor, CT 06074

Phone: 860-648-4480
Fax: 860-648-2132

Please Print

Patient's Name _____ Home Phone _____ Cell Phone _____

Parent's Name (if under 18 yrs) or Spouse if married _____ Referred By _____

Home Address _____ State _____ Zip _____

Sex M___ F___ Marital Status M___ S___ W___ D___ Birthdate _____ Age _____ Soc Sec # _____

Driver's License # _____ Nearest Relative Not Living With You _____ Phone _____

Person Financially Responsible (if other than self) _____

Address _____ Phone _____

Your Employer Name & Address _____ Work Phone _____

Primary Care Physician _____ Pharmacy – Phone & Address _____

HIPPAA- I authorize release of my health information to _____

INSURANCE COVERAGE

Primary Insurance	Secondary Insurance
Ins. Co	Ins Co
Address	Address
Subscriber Name	Subscriber Name
Relationship to Sub Self___ Spouse___ Child___ Other___	Relationship to Sub Self___ Spouse___ Child___ Other___
Subscriber's Soc. Sec. #	Subscriber Soc Sec #
Subscriber Birthdate	Subscriber Birth date
I.D. #	I.D. #
Group #	Group #
Employer Name	Employer Name

Workman's Comp	Liability
In this injury employment Related? Y___ N___	Automobile Accident? Y___ N___ Other Accident? Y___ N___
Date of Injury	Date of Accident
Employer	Do you have medical coverage on your auto ins? Y___ N___
Name & Address of Insurance	Name & Address of Insurance
Claim #	Policy or Claim #
Attorney's Name & Address	Attorney's Name & Address
Have you filed a First Report of Injury? Y___ N___	

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Eastern Orthopedics and Sports Medicine for services rendered. I understand that I am financially responsible to the doctor for charges not covered by this assignment. I also understand that even though I have insurance coverage, I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Today's Date _____ **Patient or Authorized Signature** _____