

Eastern Orthopaedics and Sports Medicine

PLEASE PRINT

DATE ____/____/____

PATIENT INFORMATION

Name _____ Male / Female Marital Status: S M W D P

Street Address _____ DOB ____/____/____

Town _____ ST _____ ZIP _____ Phone _____ Cell Phone _____

SSN ____/____/____ Drivers License # _____ Parent's Name if Child _____

Email Address _____ Emergency Contact _____ Phone _____

Employer (parent if for child) _____ Work Phone _____

Pharmacy & Town _____ Pharmacy Phone _____

Primary care Physician _____ Who referred you to our office? _____

REASON FOR TODAY'S VISIT? Please circle: Left Right Both

Shoulder Clavicle Arm Elbow Wrist Hand Finger Hip Pelvis Back Neck Leg Knee Ankle Heel Foot

HAVE X-RAYS BEEN TAKEN FOR THIS PROBLEM? Y / N WHEN? ____/____/____ WHERE? _____

IS THIS A **WORKMEN'S COMP CASE** or **AUTO ACCIDENT**? (please circle) DATE OF INJURY ____/____/____
** A separate form will be needed to complete this information. Please ask the receptionist.

DO YOU HAVE AN ATTORNEY REPRESENTING YOU? Y / N STATE WHERE INJ OR ACC OCCURRED? _____

Attorney Name _____ Phone _____

Attorney Address _____

INSURANCE INFORMATION

PRIMARY

SECONDARY

Ins. Co. _____

Inc. Co. _____

Policy Holder's ID # _____

Policy Holder's ID# _____

Group # _____
(if patient is not subscriber, please note 2 digits at end of ID number)

Group # _____
(if patient is not subscriber, please note 2 digits at end of ID number)

Subscriber's Name _____

Subscriber's Name _____

Subscriber's SSN _____

Subscriber's SSN _____

Subscriber's DOB ____/____/____

Subscriber's DOB ____/____/____

Subscriber is SELF SPOUSE PARENT SIGNIFICANT OTHER PARTNER OTHER

I have been notified of HIPAA Privacy Practices. A copy of EOSM Privacy Practices may be found in our waiting room for review.

I have authorized EOSM to speak to the following person (s) regarding my healthcare: _____

You may call my home and leave a message on an answering machine or person who answers the phone Y N

You may call my work and leave a call back number Y N You may fax to # _____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Eastern Orthopaedics and Sports Medicine for services rendered. I 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** _____