ORTHOPAEDIC SURGICAL CONSULTANT, P.C.

PATIENT INFORMATION SHEET

(PLEASE FILL OUT ALL INFORMATION)

Patient Name: Last _____ First _____

Address _____ City _____ State _____ Zip Code _____

S.S.# _____ Birth Date _____ Age _____ Male _____ Female _____

Phone #: Home _____ Work _____ Cell _____

IN CASE of Emergency Phone# _____ Relationship _____

FAMILY PHYSICIAN Name _____ Address & Phone _____

REFERRING PHYSICIAN: Name _____ Address & Phone _____

INSURANCE INFORMATION (Check One) PRIMARY _____

NO FAULT ❑ WK/COMP. ❑ OTHER INSURANCE ❑ SECONDARY _____

POLICY NUMBER/CLAIM NUMBER _____

SPOUSE'S INSURANCE _____

INSURANCE ADDRESS _____

RESPONSIBLE PARTY: (as appears on insurance cards) PATIENT'S EMPLOYER

Name: _____ Name: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Date of Birth _____ Male _____ Female _____

RELATIONSHIP TO PATIENT _____

All outstanding patient balances will be subject to a late charge of $25.00 after 60 days. Additional late fees of $20.00 will accrue for each subsequent 30 day period of non payment. Any bill outstanding for more than 120 days may be forwarded to a collection agency and a collection fee of 35% will be added to the balance due.

There will be a $30.00 charge for checks returned for insufficient funds.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered or denied services and all deductibles and co-payments. I authorize the physician to release any information required to process this claim.

Signature: _____ Date: _____

(Responsible Party)