## ORTHOPAEDIC SURGICAL CONSULTANT, P.C.

## PATIENT INFORMATION SHEET

(PLEASE FILL OUT ALL INFORMATION)

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: Address: Address:  Phone #: 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 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.	Patient Name: Last		First_			
Phone #: Home	Address	City		State	Zip Code	
Referring Physician Name	S.S.#	Birth Date	Age _	Male	Female	
REFERRING PHYSICIAN: NameAddress & Phone	Phone #: Home	Work		Cell		
REFERRING PHYSICIAN: NameAddress & Phone	IN CASE of Emergency Phone# Relationship					
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(Pagnangible Party)	Signature:	(Responsible Party)		Date:		