PATIENT NAME:

DATE OF BIRTH: SEX:

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE: CELL PHONE: SS#:

EMAIL ADDRESS:

Preferred Pharmacy: AddrLine1»
Pharmacy Phone:

RACE: _____ ETHNICITY: _____ LANGUAGE: _____

INJURY: YES or NO OCCUR AT WORK: YES or NO BODY PART: _____

IS TODAY'S VISIT AUTHORIZED BY WORKMANS COMP: YES or NO

AUTO ACCIDENT: YES or NO
IF YES WHAT STATE DID THE ACCIDENT OCCUR: _____

EMPLOYER: WORK #:

REFERRING MD: PHONE:

EMERGENCY CONTACT NAME:

RELATIONSHIP: PHONE:

INSURANCE INFORMATION

IS YOUR INSURANCE COVERAGE THE HEALTHCARE EXCHANGE? Yes or NO

PRIMARY INSURANCE: POLICY #:

NAME OF INSURED: DOB: GROUP #:

SECONDARY INSURANCE: POLICY #:

NAME OF INSURED: DOB: GROUP: #

**** IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO CONTACT YOUR PRIMARY CARE PHYSICIAN, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO REFERRAL – YOU THE PATIENT AGREE TO PAY HARTFORD ORTHOPEDIC SURGEONS, PC IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

PATIENT SIGNATURE: DATE:

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE THE OFFICE OF HARTFORD ORTHOPEDIC SURGEONS, PC. TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO HARTFORD ORTHOPEDIC SURGEONS, PC I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

PATIENT SIGNATURE: DATE: