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Welcome to Orthopaedic & Sports Medicine of Erie, P.C.

Physician: NS JD JN CS MK PW TF Appt Date/Time: ____________________

PATIENT INFORMATION

Patient Name ____________________ Sex: M F Birth Date ____________ Age______

Address ____________________ City ____________ State______ Zip__________

Home Telephone # ( ) ____________ Cell # ( ) ____________ Email ____________

Social Security # ____________ Marital Status ______ Name of Spouse ____________

Race ____________ Ethnicity ____________ Preferred Language ____________

Patient Employer ____________________ Work Phone # ( ) ____________

Employer Address ____________________ City ____________ State______ Zip__________

Referred By: Physician: ____________________ (Phone Book ___ Friend ___ Other ___)

Referring Physician Address ____________________ City ____________ State______ Zip__________

Family Physician's Name ____________________ City ____________ State______ Zip__________

Reason for Today's Visit ____________ Date of Injury __________ Previous X-rays: Yes No Where

ACCIDENT INFORMATION (Please circle): Worker's Compensation Auto Accident Other

INSURANCE INFORMATION

Primary Health Insurance Name ____________________

Address ____________________ Phone # ( ) ____________

Policy Holder Name ____________________ Birth Date ____________

Employer (Include address if known) ____________________

I.D. or Claim # ____________________ Group # ____________

Relationship To Patient Self ___ Spouse ___ Child ___ Other ___

Secondary Health Insurance Name ____________________

Address ____________________ Phone # ( ) ____________

Policy Holder Name ____________________ Birth Date ____________

Employer (Include address if known) ____________________

I.D. or Claim # ____________________ Group # ____________

Relationship To Patient Self ___ Spouse ___ Child ___ Other ___

(If Worker's Compensation or Auto Accident, Please List)

Worker's Compensation _____

Automobile Insurance _____ **Insurance Name** ____________________

Address ____________________ Phone # ( ) ____________

Policy Holder Name ____________________ Birth Date ____________

Employer (Include address if known) ____________________

I.D. or Claim # ____________________ Group # ____________

Relationship To Patient Self ___ Spouse ___ Child ___ Other ___

(OVER)

EMERGENCY CONTACT INFORMATION

NAME ______________________ RELATIONSHIP ______________________

HOME PHONE ______________________ ALTERNATE PHONE ______________________

Orthopaedic & Sports Medicine of Erie complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

RELEASE OF INFORMATION

There may be times when we would like to informally contact you with information, or when you may want us to tell others, such as family or friends, about your condition or treatment. For instance, we may need to contact you to report test results or you may want us to inform your family of how your treatment is proceeding. We refer to this type of informal communication as "Personal Communication." Please fill out this form to help guide us in providing Personal Communications about you.

1. Please indicate whom else (if anybody) we may communicate with concerning your condition and/or treatment.
   _____ No one
   _____ My Spouse, please name: ______________________
   _____ My Children, please name: ______________________
   _____ My Parent(s), please name: ______________________
   _____ My Family Physician, please name: ______________________
   _____ Others ______________________
2. May we provide Personal Communication to you by telephone?
   _____ Yes _____ No
   If yes, please list the telephone number we may use if it is other than what we currently have on file: ______________________
3. If you are not available when we call by telephone, may we provide the information to the person who answers, or leave the information on an answering machine?
   _____ Yes _____ No
4. If we use regular mail to provide Personal Communication to you we will use the address you have given us. If you want us to use an address different than what we have on file, please list it here:
   ____
   ____
5. If there are any other specific requests for restriction on Personal Communication that you would like to make, please note them here:
6. This form will remain in effect for the following term:
   _____ As long as I am a patient _____ This treatment and follow-up only _____ Other ______________________

I understand the following with respect to this form:

- I may refuse to complete/sign this form. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- If the person(s) receiving information about me through Personal Communication is to a health care provider or a health plan covered by Federal Privacy Regulations, the information may be redisclosed and no longer protected by Federal Privacy Regulations.
- I may change or revoke this form in writing to you anytime, for future Personal Communications.
- If Orthopaedic & Sports Medicine of Erie is able to agree to this request, it will supersede any previous made for this patient. Orthopaedic & Sports Medicine of Erie. will notify you if unable to agree to any section of this request.

______________________ ______________________
Signature of patient or patient's legal representative Date

____
Print patient's name

______________________ ______________________
Print name of legal representative (if applicable) Relationship to patient

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize **Orthopaedic & Sports Medicine of Erie** to furnish information to insurance carriers concerning my illness and treatments. I hereby authorize payment directly to the physician for medical and/or surgical benefits, if any, otherwise payable to myself or my dependents for his/her services as described by the statement of services rendered. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree, that if for any reason, my insurance company does not pay for visits and/or related services or supplies, I will accept responsibility for any/all charges incurred and balance must be paid within 90-120 days, unless satisfactory financial arrangements are made. This policy shall remain in effect for the duration of my care,

I consent to treatment necessary for the care of the above-named patient.

I hereby authorize **Orthopaedic & Sports Medicine of Erie** to release or obtain all my medical records to or from the referring physician, family physician, transferring physician and/or my insurance company, if applicable.

I allow fax transmittal of my medical records.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization. I agree that a photocopy of this authorization may be considered a valid authorization. I understand that I can revoke this authorization at anytime by notifying **Orthopaedic & Sports Medicine of Erie** in writing.

Date ______________________ Signature Required ______________________