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PATIENT NAME: _____
FIRST NAME MIDDLE INITIAL LAST NAME

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ SEX: M F DATE OF BIRTH: _____ AGE: _____

HOME PHONE: _____ WORK PHONE: _____ SS#: _____ MARITAL STATUS: S M D W

EMPLOYER: _____ EMPLOYER ADDRESS: _____

REFERRING PHYSICIAN/FRIEND: _____

SPOUSES EMPLOYER: _____

SPOUSES EMPLOYERS ADDRESS: _____

SPOUSES WORK PHONE: _____

IF FULL-TIME STUDENT INDICATE SCHOOL CURRENTLY ATTENDING: _____

NATURE OF PROBLEM AND DATE OF ONSET: _____

PAST MEDICAL HISTORY: _____

PAST SURGICAL HISTORY: _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

PRIMARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

ADDRESS: _____ TELEPHONE #: _____

RELATIONSHIP TO INSURED: _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): _____

SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): _____

DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): _____

SECONDARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

ADDRESS: _____ TELEPHONE #: _____

RELATIONSHIP TO INSURED: _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): _____

SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): _____

DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): _____

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO ORTHOPAEDIC SURGEONS OF L.I., ASSOCIATES FOR SERVICES DESCRIBED. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR SERVICES INCLUDING REASONABLE ATTORNEY FEES AND COSTS OF COLLECTION IN THE EVENT OF DEFAULT.

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATIONS OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNED: _____ DATE: _____

PLEASE ADVISE FRONT DESK STAFF IF YOU WERE INJURED IN A CAR ACCIDENT OR ON THE JOB