## PATIENT INFORMATION

DATE _____ OFFICE_____ DOCTOR_____ BIRTHDATE _____

PATIENT NAME _____ SOC. SEC.# _____
FIRST MIDDLE LAST

ADDRESS_____ CITY, STATE, ZIP _____
STREET APT.

PHONE# ( )_____ CELL PHONE# _____ E-MAIL_____ MARITAL STATUS _____

EMPLOYER _____ PHONE # ( )_____

EMPLOYMENT ____ FULL ____ PART STUDENT ____ FULL ____ PART AGE_____ SEX M F

REFERRED BY _____ CITY_____ PHONE # ( )_____

FAMILY PHYSICIAN_____ CITY_____ PHONE # ( )_____

IN CASE OF AN EMERGENCY, PLEASE NOTIFY_____

## INSURANCE INFORMATION

PLEASE COMPLETE THE FOLLOWING, FOR THE PERSON/S WHO HOLD THE INSURANCE/S

**PRIMARY INSURANCE**

NAME _____ SOC. SEC. #_____
FIRST MIDDLE LAST
**(If different from patient)**

ADDRESS_____ CITY, STATE, ZIP _____
STREET APT.

PHONE # ( ) _____ BIRTH DATE_____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ PHONE # ( ) _____

INSURANCE CO._____
NAME OF INSURANCE COMPANY ADDRESS

CONTRACT # _____ GROUP #_____

**SECONDARY INSURANCE**

NAME _____ SOC. SEC # _____
FIRST MIDDLE LAST
**( If different from patient)**

ADDRESS_____ CITY, STATE, ZIP _____
STREET APT.

PHONE # ( )_____ BIRTH DATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ PHONE # ( ) _____

INSURANCE CO._____
NAME OF INSURANCE COMPANY ADDRESS

CONTRACT # _____ GROUP # _____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION:
By signing this document, I authorize the Center of Orthopedic Surgery, (COS) to use and disclose my health information for the Center of Orthopedic Surgery's treatment, payment and health care operations activities (as those terms are defined under the Health Insurance Portability and Accountability Act of 1996), including but not limited to agents and other persons or entities assisting COS in its treatment, payment and health care operations activities, as well as to my family members and/or friends who are involved in my treatment or payment for my treatment. I authorize alternate forms of communication from COS through my cell phone and/or email address that I have provided. I acknowledge the receipt of COS's Notice of Privacy Practices. I hereby agree to pay any and all co-pays, deductibles, amounts over UCR, and/or excluded charges, exceeding payments from insurances with whom COS does not except assignment with, and/or any and all co-pays and deductibles with those they do.
I hereby request my insurance carrier to pay, on my behalf, insurance benefits to COS for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if necessary, credit bureau reports may be obtained. COS can not be responsible for collecting my insurance claim nor for negotiating a settlement on a disputed claim. COS's fees aren't established by insurance companies. I am responsible for my account.

**X** _____ Date: _____