



John C. Kefalas, M.D., S.C.
 Board Certified in Orthopedic Surgery

Last Name		First Name		MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Birth Date	Age	Soc. Sec. No.		Driver's License No.		
Home Address		City	State	Zip	Home Phone	Work Phone
Primary Care Physician		How did you hear about our practice?				
Emergency Phone		Emergency Contact		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Widow		
Patient Employer Information						
Employer's Name				Employer's Phone		
Employer's Address		City	State	Zip		
Is condition work-related and authorized as a Worker's Compensation care? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Is this condition due to a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this condition due to any other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Employer's Address		City	State	Zip		
Billing Information						
Last Name		First Name		MI		
Birth Date	Age	Soc. Sec. No.		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Employer's Name				Employer's Phone		
Employer's Address		City	State	Zip		
Primary Insurance (Please skip if a copy of insurance cards have been provided)						
Primary Insurance Company		Policy Holder Name		Other Insurance Company		Policy Holder Name
Birth Date	Age	Soc. Sec. No.		Birth Date	Age	Soc. Sec. No.
Address	City	State	Zip	Address	City	State Zip
Insurance ID No.	Group Policy No.	Insurance Phone		Insurance ID No.	Group Policy No.	Insurance Phone

I hereby authorize the physician to release to any party responsible for payment any information acquired in the course of medical examinations or treatment. A Photostat of the authorization shall be considered as effective and valid as the original. I request that payment of authorized Medicare benefits be made to me or my behalf to the party who accept assignment for any services furnished me by the supplier. I authorize any holder of medical information about me to release to the health care financing administration and it agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize the physician to receive direct payment for the amount due me in my pending claim for physician's services rendered. I understand that I am financially responsible for charges not covered by this authorization. A Photostat of the authorization shall be considered as effective and valid as the original.

 Signature)

 Date