PATIENT INFORMATION

PATIENT INFORMATION

Patient Full Name: _____ Preferred Name: _____

Date of Birth: _____ Race: _____ Sex: M F Martial Status: M W D S

Primary Phone Number: _____ Alternate: _____

Email: _____ Social Security Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Family Doctor: _____ Phone: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Patient Employer: _____ Job Duties: _____

How were you referred to our office? (Please Circle)
Family Doctor Athletic Trainer Social Media Google Search Family/Friend Urgent Care: _____

INJURY INFORMATION

Body Part: _____ Side: _____ Date of Injury: _____

Explain How Injury Occurred: _____

Is this an Auto or Worker's Comp Claim? ___ No ___ Yes

If yes, Name of Carrier: _____ Claim Number: _____
Name of Adjuster: _____ Phone: _____

Is there a Lawsuit Filed? ___ No ___ Yes

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Contract/ID Number: _____ Group: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Employer: _____

Secondary Insurance Carrier: _____

Contract/ID Number: _____ Group: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Employer: _____

AUTHORIZATION TO DISCLOSE AND/OR REQUEST MY PROTECTED HEALTH INFORMATION (Please Read and Sign)

I authorize Sardelli Orthopaedics, PLLC to furnish my protected health information to insurance carriers (including but not limited to the Center for Medicare and Medicaid) concerning my illness and treatment regarding related claims, in any form of media, whether electronic, paper, or oral. I authorize Sardelli Orthopaedics, PLLC to release my personal health information including my social security number to third parties for the collection of outstanding medical bills. I understand that I am responsible for all services not covered by my insurance. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be payable to Sardelli Orthopaedics, PLLC. I also authorize the request for release of my medical records from any hospital or other facility at which I have been evaluated and treated.

Patient Signature: _____ Date: _____

Relationship if other than Patient: _____