MOORE ORTHOPEDICS AND SPORTS MEDICINE

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE NAME

ADDRESS | CITY | STATE | ZIPCODE

HOME PHONE | WORK PHONE | MOBILE PHONE (000) 000-0000

PATIENT EMAIL

EMERGENCY CONTACT NAME | EMERGENCY PHONE | RELATIONSHIP

DATE OF BIRTH | MALE ☐ FEMALE ☐ OTHER ☐ | SOCIAL SECURITY NO. NNN-NN-NNNN

MARITAL STATUS | RACE | ETHNICITY | LANGUAGE

EMPLOYER | EMPLOYER PHONE

REFERRING PHYSICIAN | PATIENT'S PHYSICIAN

Do you give permission for copies of your records to be sent to your family and/or requesting physicians?
☐ YES ☐ NO

Do you give permission for copies of your records to be sent to any hospital and/or reffering physicians?
☐ YES ☐ NO

Was this an injury? ☐ YES ☐ NO

Where did the injury occur? ☐ AUTO ☐ WORK ☐ OTHER

Were x-rays taken? ☐ YES ☐ NO

Date of injury? (IF YES PLEASE BRING X-RAY DISK & INJURY REPORT) Date of x-rays?

GUARANTOR INFORMATION

NAME | ADDRESS | RELATIONSHIP TO PATIENT

GUARANTOR DOB

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME | POLICY HOLDER NAME (if other than patient) | DOB

ADDRESS | CITY | STATE | ZIPCODE

ID / CERTIFICATION NO. | POLICY / GROUP NO. | MALE ☐ FEMALE ☐ OTHER ☐

SECONDARY INSURANCE PLAN | POLICY HOLDER NAME (if other than patient) | RELATIONSHIP TO PATIENT

ID / CERTIFICATION NO. | POLICY / GROUP NO.

ASSIGNMENT AND RELEASE

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process this claim. I authorize my provider's office to contact me by phone to remind me of my appointments. A fee for no shows may apply. The undersigned hereby acknowleges receipt of a copy of the Notice of Privacy Practices of Moore Orthopedics and Sports Medicine, P.A.

SIGNATURE **DATE** MM/DD/YYYY