Patient Information

ORTHOPAEDIC ASSOCIATES, LLP

❑ Dr. Gregory Harvey ❑ Dr. Vivek Kushwaha ❑ Dr. Alan Rechter ❑ Dr. Navin Subramanian ❑ Dr. David Lin ❑ Dr. Amy Riedel ❑ Dr. Justin Chronister

PATIENT NAME (First Name, Middle Initial, Last Name) PATIENT ID (Office Use Only)		Office ( ) -	Home ( ) -	THIRD PHONE (MOBILE) ( ) -
ADDRESS DATE OF BIRTH		SOCIAL SECURITY NUMBER	SEX (M OR F) ❑ M ❑ F	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ OTHER
CITY, STATE, ZIP AGE		EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER		OCCUPATION	PATIENT EMAIL ADDRESS	
REFERRING DOCTOR NAME AND ADDRESS				
PRIMARY CARE DOCTOR NAME AND ADDRESS				
RACE		ETHNICITY		
PHARMACY NAME		ZIP CODE	PHARMACY PHONE NUMBER	
NAME OF AUTHORIZED PARTIES THAT MAY DISCUSS MEDICAL CARE			CONTACT NUMBER	

Is it okay to leave test results on voice mail? ❑ YES ❑ NO

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	Office ( ) -	Home ( ) -	THIRD PHONE (MOBILE) ( ) -
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		SEX (M OR F) ❑ M ❑ F	PATIENT'S RELATION TO RESP
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE):
❑ Patient (same as above) ❑ Responsible Party (same as above) ❑ Other (complete below)

INSURANCE COMPANY NAME CO-PAY AMOUNT		INSURED'S NAME (First Name, Middle Initial, Last Name)	
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP	
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH	
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M OR F) ❑ M ❑ F / PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #		INSURED'S EMPLOYER	INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE):
❑ Patient (same as above) ❑ Responsible Party (same as above) ❑ Other (complete below)

INSURANCE COMPANY NAME CO-PAY AMOUNT		INSURED'S NAME (First Name, Middle Initial, Last Name)	
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP	
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH	
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M OR F) ❑ M ❑ F / PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #		INSURED'S EMPLOYER	INSURED'S OCCUPATION

Responsible Party

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize ORTHOPAEDIC ASSOCIATES, LLP to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

_____ _____ _____

Signature of Patient / Parent / Guardian Printed Name Date

I / We authorize direct payment to be made to ORTHOPAEDIC ASSOCIATES, LLP for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

_____ _____ _____

Signature of Patient / Parent / Guardian Printed Name Date