ORTHOPAEDIC & SPORTS ASSOCIATES of Long Island

PLEASE ANSWER ALL QUESTIONS

TODAY'S DATE: _____

PATIENT'S NAME: _____

ADDRESS: _____

TOWN: _____

ZIP CODE: _____

TELEPHONE HOME: _____

TELEPHONE WORK: _____

TELEPHONE CELL: _____

E-MAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

IF UNDER 18, PARENT'S NAME:

_____

DATE OF BIRTH: _____ /_____ /_____ SEX: M F

PATIENT'S AGE: _____

REASON FOR VISIT (BODY PART) _____

_____

HOW DID IT HAPPEN? (NF / WC) _____

_____

WAS THIS WORK RELATED? YES NO

WERE YOU IN A CAR ACCIDENT? YES NO

DATE SYMPTOMS STARTED: _____

LEFT OR RIGHT: _____

WERE X-RAYS TAKEN: YES NO

WHERE? _____

DATE OF X-RAYS: _____

HOW DID YOU HEAR ABOUT US? (CIRCLE ONE) PRIMARY CARE PHYSICIAN SOCIAL MEDIA ADVERTISING FAMILY/FRIEND

OTHER (PLEASE LIST): _____

REFERRING DR.: _____ **TELEPHONE NO.**: _____

ADDRESS: _____

FAMILY DOCTOR: _____ **TELEPHONE NO.**: _____

NAME & LOCATION OF PHARMACY: _____ **PHARMACY NO.:** _____

INSURANCE INFORMATION

NAME OF *PRIMARY* INSURANCE

_____

ADDRESS OF INSURANCE COMPANY

_____

POLICY HOLDER: _____

SOCIAL SECURITY NO.: _____

DATE OF BIRTH: _____

NAME OF INSURED'S EMPLOYER

_____

POLICY NUMBER GROUP NUMBER

_____

RELATIONSHIP TO PATIENT

_____

NAME OF *SECONDARY* INSURANCE

_____

ADDRESS OF INSURANCE COMPANY

_____

POLICY HOLDER: _____

SOCIAL SECURITY NO.: _____

DATE OF BIRTH: _____

NAME OF INSURED'S EMPLOYER

_____

POLICY NUMBER GROUP NUMBER

_____

RELATIONSHIP TO PATIENT

_____

INSURANCE PAYMENT ORDER

I authorize the release of any medical information necessary to process an insurance claim and authorize direct payment to ORTHOPAEDIC & SPORTS ASSOCIATES OF LONG ISLAND, P.C.. I understand that I am financially responsible for treatment rendered.
(If insured is a minor, parent or guardian must sign).

LEGAL SIGNATURE: _____ **DATE:** _____