

ORTHOPEDIC ASSOCIATES OF MIDDLETOWN, P.C.

PATIENT INFORMATION FORM

DATE: _____

How did you hear about us? Yellow Book SBC Yellow Pages Primary Care Dr. Internet Other

Patient's Name (First, Middle, Last) _____

Date of Birth _____ Social Security No. _____

Patient's Address _____ Apt. No. _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone () _____ Cell Phone No. _____

Sex: M F

Primary Care Physician's Name _____ Phone () _____

Referring Doctor _____

Address _____ City, State, Zip _____

SPOUSE OR CONTACT INFORMATION

Name _____

Date of Birth _____ Social Security No. _____

Employer _____ Employer's Phone () _____

FILL IN IF PATIENT IS A MINOR

Father's Name (First, Middle, Last) _____

Date of Birth _____ Social Security No. _____

Employer _____ Employer's Phone () _____

Mother's Name (First, Middle, Last) _____

Date of Birth _____ Social Security No. _____

Employer _____ Employer's Phone () _____

EMERGENCY CONTACT-Not in same household _____

Phone () _____

ACCIDENT INFORMATION-(Please Check One) Work Injury Automobile Injury Other

Date of Accident and Description _____

Employer at Time of Accident _____ Employer's Address _____

INSURANCE

PRIMARY INSURANCE _____ Person Who Carries Insurance _____

SECONDARY INSURANCE _____ Person Who Carries Insurance _____

EMPLOYER

Employer Name _____ Address _____

Work Phone () _____

Patient Acknowledgement of Receipt of Notice of Privacy Practices

OAM has provided me with a Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:

Privacy Contact (860-347-7637 X6023)

Or

Privacy Officer (860-347-7636 X6037)

I also understand that I am entitled to receive updates upon request if Orthopedic Associates of Middletown's Notice of Privacy Practices is amended or changed in a material way.

Signature

Relationship to Patient, if signed by someone other than the patient

Date

Assignment of Medical Benefits/Guarantee of Financial Responsibility

I request that payment of authorized medical benefits be made directly to Orthopedic Associates of Middletown, PC. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am Financially Responsible for all charges whether or not paid by said insurance. In the event that I fail to pay charges due and Orthopedic Associates of Middletown, PC refers my account to collection, I agree to pay cost of collections including a reasonable attorney's fee.

For Medicare patients, this applies to the Social Security Administration, Centers for Medicare and Medicaid Services or its intermediaries or carriers.

Patient or Legal Guardian Signature

Date

DO NOT WRITE BELOW THIS LINE, FOR OFFICE USE ONLY!!!

TO BE COMPLETED BY OAM IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FORM PATIENT

On, _____, I made a good faith effort to obtain a written acknowledgement of receipt of Notice of Privacy Practices from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledge.

Other (specify): _____

Name and title of employee

Date