PATIENT INFORMATION

All information will be kept confidential.

Patient Name: First, M.I. Last	**Social Security Number**

Address: Street-City- State-Zip

Employer	Date of Birth	Age	Gender M F

Home Phone	Work Phone	Cell/other phone

Preferred Pharmacy: (Name, Location and/or Phone Number) **Primary Physician:**

E-mail address(es)

Emergency Contact Name, Phone Number and Relation:

Preferred Method of Contact: { } E-Mail { } Phone { } Other:_____

Race: { } American Indian/Alaska Native { } Asian { }Black/African American { } Hispanic { }Native Hawaiian
{ } Other Pacific Islander { } White { } Other Race

Ethnicity: { } Hispanic or Latino { } Non-Hispanic or Latino

Preferred or Primary Language: { } English { } Indian(Includes Hindi & Tamil) { } Spanish { }Russian { } Other

IF PATIENT IS A MINOR, PLEASE FILL OUT PARENT/GUARDIAN INFORMATION BELOW

Father	Employer	Business phone Other phone
Mother	Employer	Business phone Other phone

INSURANCE INFORMATION: PLEASE SHOW YOUR HEALTH INSURANCE CARD TO THE RECEPTIONIST. CO-PAYS ARE DUE AT THE TIME OF THE APPOINTMENT

Primary Insurance	Policy holder	Relationship to Patient	Policy Holder DOB

ID# or Policy#	Group#	Claims mailing address

Secondary Insurance	Policy holder	Relationship to Patient	Policy Holder DOB

ID# or Policy#	Group#	Claims mailing address

[ ] WORKERS COMPENSATION [ ] AUTOMOBILE/LIABILITY

Insurance Carrier	Address

Employer at time of injury	Contact name/phone

Policy/Claim #	Part of body injured	Date of injury

INFORMATION RELEASE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I verify that the information provided is correct. I understand that I am financially responsible for any charges not covered under my insurance policy. By signing this release, I authorize the release of any medical information necessary to process my health insurance claims. Release of my information to any other party will require a separate signed authorization.

I hereby request and authorize direct payment of benefits specified under my insurance policy to be made directly to Silverman Orthopaedics, P.C. Any balance left after the insurance payment has been received will be due in full within 90 days of notification from this office. I understand that I am financially responsible for the charges as a result of the services I receive. I understand that I will be responsible for any charges not covered by my insurance policy contract. It is my responsibility to inform Silverman Orthopaedics, P.C. of any changes to my insurance. It is my responsibility to obtain authorization for treatment by Lance Silverman, M.D. prior to receiving the treatment.

A photocopy or exact reproduction of this authorization shall have the same force and effect of this original.

PLEASE MAKE CHECKS PAYABLE TO SILVERMAN ORTHOPAEDICS, P.C.

Patient/Responsible Party Signature_____ Date: _____

Information verified; no changes _____ initial/date