slocum center for orthopedics & sports medicine

Date: _____

Patient's Legal Name: _____ Birthdate: _____
LAST FIRST MI

Mailing Address: _____ Age: _____

City: _____ State: _____ Zip: _____ Sex: M ( ) F ( )

Street Address if different: _____ Marital Status: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Employer: _____

Email _____ Driver's License#: _____ State: _____

Spouse: _____ Employer: _____

Work Phone: ( ) _____ Occupation: _____

Family Doctor: _____ Phone: ( ) _____

Address: _____
(Street) (City) (St) (Zip)

Referring Physician: _____ Phone: ( ) _____

Address: _____
(Street) (City) (St) (Zip)

Responsible Party (if minor): _____

Employer: _____ Work Phone: ( ) _____ Occupation: _____

Nearest Relative (not living with you): _____

Phone: ( ) _____ Relationship to Patient: _____

Explain circumstances of injury or onset in detail, state accident occurred, and date: _____

_____

Is this an On The Job Injury? ☐ Yes ☐ No If yes, Claim number: _____

Employer at time of injury: _____ Work Comp. Carrier: _____

Date of injury: _____ Status of Claim: ☐ Open ☐ Closed ☐ Deferred ☐ Denied Date: _____

Is this a Motor Vehicle Injury? ☐ Yes ☐ No If yes, Claim number: _____

Auto Insurance Carrier: _____ Agent Name: _____ Phone: ( ) _____

Date of injury: _____ Status of Claim: ☐ Open ☐ Closed ☐ Deferred ☐ Denied Date: _____

Do you have an attorney in regards to this injury? ☐ Yes ☐ No

Attorney Name: _____ Phone: ( ) _____ City: _____

HEALTH INSURANCE INFORMATION

PATIENT'S NAME: _____ DATE:_____

Primary Insurance: _____

Subscriber:_____ Relationship to Patient:_____

Employer: _____ Phone: ( ) _____ Effective Date: _____

Subscriber ID#: _____ GRP#: _____ DOB_____/_____/_____

Secondary Insurance: _____

Subscriber:_____ Relationship to Patient: _____

Employer: _____ Phone: ( ) _____ Effective Date: _____

Subscriber ID#: _____ GRP#: _____ DOB_____/_____/_____

Third Insurance: _____

Subscriber:_____ Relationship to Patient: _____

Employer: _____ Phone: ( ) _____ Effective Date: _____

Subscriber ID#: _____ GRP#: _____ DOB_____/_____/_____

ASSIGNMENTS OF BENEFIT AND ACKNOWLEDGEMENT THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES

1. I hereby assign to Slocum Orthopedics all money (not to exceed my indebtedness) to which I am entitled for medical or surgical expense for such charges incurred with Slocum Orthopedics on my behalf or at my request.
2. I understand that I may be responsible for the payment of the bill regardless of whether the charges may be covered by insurance or also be the responsibility of some other party. This includes supplies, which I may receive that are not covered by my Medicare or other plans.
3. I hereby authorize Medicare/Travelers Medicare to release information regarding any claim, assigned or unassigned, to Slocum Orthopedics.
4. If Slocum Orthopedics engages an attorney to collect the fees and charges owed, I will pay the reasonable attorney fees incurred by Slocum Orthopedics in any suit, action, or subsequent appeal.
5. I understand my email address will be used to send educational information, practice updates and invitations to participate in an online patient satisfaction survey. Each email contains a link to opt out of receiving future communication if I so choose.
6. I hereby give Slocum Orthopedics permission to send Customer Satisfaction Survey Studies to the email address on side 1 of this form.
7. By signing below I agree I have received a copy of the **Notice of Privacy Practice**.

_____ _____

Patient's Signature Date

_____ _____

Parent/Legal Guardian/Rep. Signature Print Rep. Name and relationship to patient

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Internal use only

Notice of Privacy Practice given to patient, unable to obtain signature

_____

Slocum Employee signature **Date**