

## CHESTER COUNTY ORTHOPAEDIC ASSOCIATES, LTD.

Patient: (Mr., Mrs., Ms., Dr.)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel # (\_\_\_\_\_) \_\_\_\_\_ Business Tel # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Cell # \_\_\_\_\_

**Social Security #** \_\_\_\_\_ Sex:  Male  Female **Date of Birth** \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ **Family Physician** \_\_\_\_\_

How were you referred to the practice? \_\_\_\_\_

Patient: Who will be responsible for your account?  Self  Spouse  Father  Mother  Other

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Tel # (\_\_\_\_\_) \_\_\_\_\_

Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### INSURANCE INFORMATION: AS IT APPEARS ON YOUR CARD

**Primary Ins. Co.:** \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_

Subscriber Social Security: \_\_\_\_\_

Group No.: \_\_\_\_\_ I.D. No.: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child  Other

#### FOR MEDICARE PATIENTS ONLY

Secondary Ins. Co.: \_\_\_\_\_

Ins Co. Name: \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_

Group No.: \_\_\_\_\_ I.D. No.: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child  Other

### FOR WORKMAN'S COMPENSATION OR AUTO CLAIMS - COMPLETE THE FOLLOWING

Is this Related to Employment?  Yes  No

Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

Worker Comp. Ins. Co.: \_\_\_\_\_

Address: \_\_\_\_\_

Ins. Co. Phone #: (\_\_\_\_\_) \_\_\_\_\_

Employer Contact: \_\_\_\_\_

Contact Phone #: (\_\_\_\_\_) \_\_\_\_\_

Is this Related to an Auto Accident?  Yes  No

Date of Accident: \_\_\_\_\_ Claim #: \_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

\_\_\_\_\_

Ins. Co. Phone No.: (\_\_\_\_\_) \_\_\_\_\_

Insured Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Tel # (\_\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_

### EMERGENCY INFORMATION

For All Patients: In an Emergency. List the Names and Phone Numbers of Two People We Can Contact:

Name: \_\_\_\_\_ Phone No.: (\_\_\_\_\_) \_\_\_\_\_ Name: \_\_\_\_\_ Phone No.: (\_\_\_\_\_) \_\_\_\_\_

#### FOR ALL PATIENTS: AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize release of information as well as payment to Chester County Orthopaedic Associates, Ltd.

Signature of Insured /Responsible Person: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR MEDICARE PATIENTS ONLY:** I hereby request the payment of authorized Medicare benefits to be made either to me or on my behalf to Chester County Orthopaedic Associates, Ltd., for any services furnished me by any one of the physicians in the above named group.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_