Date ____________________

PATIENT SOCIAL SECURITY # ____________________

Name ____________________ M F
LAST FIRST

Address ____________________
STREET

City ____________________
STATE ZIP

Telephone __________ Work __________ Cell __________

Birthdate ____________________ Age __________

Marital Status ____________________

If minor, parents first name ____________________

If married, spouses first name ____________________

Name you may have previously been seen under ____________________

PRIMARY HEALTH INSURANCE

Name of Insurance Company ____________________

Identification # ____________________

Group __________ Plan __________

Subscriber's Name ____________________

Subscriber's Social Security # ____________________

Subscriber's Date of Birth ____________________

Subscriber's Employer ____________________

SECONDARY HEALTH INSURANCE

Name of Insurance Company ____________________

Identification # ____________________

Group __________ Plan __________

Subscriber's Name ____________________

Subscriber's Social Security # ____________________

Subscriber's Date of Birth ____________________

Subscriber's Employer ____________________

Name of Medical Doctor ____________________

Name of Referring Doctor/Hospital ____________________

WORK RELATED INJURY

Employer Name ____________________

Address ____________________
STREET

City ____________________
STATE ZIP

Your Social Security # ____________________

Did injury occur at work? YES NO

Date of Injury ____________________

Insurance Carrier ____________________

Address ____________________
STREET

City ____________________
STATE ZIP

Carrier Case # ____________________

AUTO ACCIDENT

Did injury occur in auto accident? YES NO

Date of Accident ____________________

Insurance Carrier ____________________

Address ____________________
STREET

City ____________________
STATE ZIP

Telephone ____________________

SCHENECTADY REGIONAL ORTHOPEDIC ASSOCIATES, P.C.

Statement to Authorize Payment of Insurance Benefits

I certify that the information I have given in applying for payment for my insurance company or under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to my insurance company or the Social Security Administration, or its Carriers, any information required to process my Medicare or other insurance claims.

I request that payment under the medical insurance program be made either to me or to SCHENECTADY REGIONAL ORTHOPEDIC ASSOCIATES for services rendered.

____

Signature

____

Date