SOUTH SHORE ORTHOPAEDIC ASSOCIATES, P.C.
PATIENT INFORMATION

Date: _____ Account #: _____

Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____ Age: _____

City: _____ ST: _____ ZIP: _____ Height: _____ Weight: _____

Home Phone #: _____ Marital Status: _____ Spouse's Name: _____

Cell Phone #: _____ If patient is a minor, mother & father's name(s) _____

May we contact you and leave a message on your (answering machine y/n) (cell phone y/n) (fax y/n) (mail y/n)

Race: _____ Ethnicity: Hispanic / Non-Hispanic Preferred Language: English/Spanish

Primary Care Physician: _____ Referred by: _____

Pharmacy Name: _____ Address: _____ Phone #: _____

Employer: _____ Phone #: _____ Address: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____ SS#:_____

Address: _____ Home Phone #: _____

Employer: _____ Relationship to patient: _____

PRIMARY INSURANCE INFORMATION	**SECONDARY INSURANCE INFORMATION**
Insurance Name: _____	Insurance Name: _____
ID #: _____ Group #: _____	ID#: _____ Group #: _____
Policyholder: _____ Copay: _____	Policyholder: _____ Copay:_____

Job Related: Yes or No
Auto Accident: Yes or No

Did you have any x-rays or MRIs? Yes or No
If yes, where? _____

Date of Injury/Problem: _____ Which body part did you injure? _____

Place where injury/problem occurred: _____

How did the injury/problem occur? _____

I have received and read a copy of the Privacy Notice: *****Please sign: _____

I hereby assign my insurance benefits to be paid directly to the undersigned physician. I am financially responsible for non-covered services. I hereby authorize the release of medical information related to the services described herein. I authorize medicare, if applicable, to submit payment for services rendered.

Patient's or Authorized Signature: _____