

Greater Hartford Orthopedic Group, P.C.

Patient Information

WELCOME TO OUR OFFICE

Date:

PATIENT'S NAME (PLEASE PRINT)	S.S.#	MARITAL STATUS	SEX	BIRTH DATE	AGE
		S M W D	M F		
STREET ADDRESS	CITY & STATE		ZIP CODE	HOME PHONE#	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE# & EXT.#		
EMPLOYER'S STREET ADDRESS	CITY & STATE		ZIP CODE		
SPOUSE OR PARENT'S NAME	SPOUSE/PARENT'S ADDRESS (IF DIVORCED)		S.S.#	D.O.B.	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE# & EXT.#		
EMPLOYER'S STREET ADDRESS	CITY & STATE		ZIP CODE		

Health Insurance Information

Relationship to Subscriber: Self Spouse Dependent

PLEASE FILL OUT COMPLETELY & ACCURATELY	<i>If you do not have health care coverage, please check here _____</i>				
PRIMARY INSURANCE	SUBSCRIBER'S NAME			BIRTH DATE	
				Copay Amount \$	
I.D. #	GROUP #		REFERRALS NEEDED? YES or NO		
SUBSCRIBER'S EMPLOYER	EMPLOYER'S ADDRESS		CITY/STATE/ZIP CODE		
PRIMARY CARE PHYSICIAN'S NAME & PHONE #	REFERRING PHYSICIAN'S NAME & PHONE #				
SECONDARY INSURANCE	SUBSCRIBER'S NAME			EFFECTIVE DATE:	
				Copay Amount \$	
I.D. #	GROUP #		REFERRAL NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S EMPLOYER	EMPLOYER'S ADDRESS		CITY/STATE/ZIP CODE		

Worker's Compensation Insurance

DATE OF INJURY:	NATURE OF INJURY:	
NAME OF INSURANCE COMPANY	STREET ADDRESS:	CITY/STATE/ZIP
CLAIM #:	ADJUSTER'S NAME & PHONE#:	
EMPLOYER:	STREET ADDRESS:	CITY/STATE/ZIP
EMPLOYER CONTACT:	PHONE #:	

Automobile, No-Fault or Liability Insurance

Was an automobile involved? YES NO

DATE OF ACCIDENT:	NATURE OF INJURY:	
NAME OF INSURANCE COMPANY	STREET ADDRESS:	CITY/STATE/ZIP
NAME OF POLICY HOLDER:	ADJUSTER'S NAME & PHONE#:	
POLICY #:	CLAIM #:	
NAME OF ATTORNEY:	STREET ADDRESS:	CITY/STATE/ZIP

BENEFICIARY/GUARANTOR SIGNATURE: I request that payment of authorized insurance, Medicaid and/or Medicare benefits be made on my or my child's behalf to Greater Hartford Orthopedic Group, P.C. for any services rendered. I authorize any holder of medical information about me or my child to be released to the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) and its agents or my insurance company any information needed to determine the benefits payable including HIV/AIDS, substance abuse, and/or mental health information for related services. I further agree to make payment for any and all services not paid for by my health insurance plan. I have been provided an opportunity to review the Greater Hartford Orthopedic Group's HIPAA Notice of Privacy Practices.

X

Signature of Beneficiary/Guarantor

Date