



PATIENT INFORMATION FORM

(Subscriber = Insurance card holder)

Appointment Date

Answers to Questions Below ARE Required by the Federal Government American Recovery & Reinvestment Act of 2009

Form section containing Social Security #, Date of Birth, Marital Status, Patient Name, SEX, Race, Ethnicity, Language, and Employment Status.

Mailing Address, City, State, Zip Code

Email Address, Home #, Mobile #, Work # & Extension

Employer, Employer Street Address, City, State, Zip Code

Referring Physician, Primary Care Physician, Referral Source, Primary Insurance Plan Name, Group #, Effective Date, Insurance ID #, Visit Copay \$ Amount, Deductible \$ Amount, Subscriber information.

Emergency Contact, Relationship to Patient, Name (F/M/L), Contact Phone #, Work #

PARENT / GUARDIAN INFORMATION

Patient's Relationship, Name (F/M/L), Social Security #, DOB

Pharmacy Name/Address, Phone #

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of Injury, Nature of Injury, State of Injury if not Connecticut, Work Comp Company Name & Address, Claim #, Adjuster's Name, Adjuster's Phone #, Employer, Employer's Address, Employer's Phone #, Name of Employer's Inside Contact Person, Position, Contact Phone #

AUTOMOBILE / NO-FAULT / LIABILITY / INSURANCE INFORMATION

Date of Accident, Nature of Injury, State of Injury if not Connecticut, Name of Insurance Company, Address, Name of Policy Holder, Adjuster's Name, Adjuster's Phone #, Policy #, Claim #, Attorney Name, Attorney Address, Attorney Phone #

BENEFICIARY/GUARANTOR: I request that payment of authorized insurance, Medicaid and Medicare benefits be made on my or my dependent's behalf to Greater Hartford Orthopedic Group, P.C. (GHOG) for services rendered to me by a GHOG physician. I authorize any holder of medical information about me or my dependent to release to the Centers for Medicare and Medicaid Services and its agents or my insurance company any information needed to determine 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 to include, but not limited to, office visit copays, x-ray copays, DME brace copays, and all deductible amounts stipulated in my contract agreement with my health insurance plan. I have been provided an opportunity to review the HIPAA Notice of Privacy Practices of Greater Hartford Orthopedic Group, P.C.

Signature of Beneficiary/Guarantor, Date, Revised October 2011