Bayside Orthopaedic, Sports Medicine & Rehabilitation Center

Please PRINT – All information must be completed.

PATIENT INFORMATION

Name (first, M.I., last):

____

Date of Birth: _______________Age:________ Male / Female Your Social Security Number_______________

Address: City: State: Zip:

____

Phone#: Work #: Cell #

____

Referring Physician: Phone #:

____

Your Primary Care Physician: Phone #:

____

Parent / Spouse Name: Date of Birth: Relationship: Parent Spouse

____

Emergency Contact: Relationship: Phone #:
(someone outside of home)

____

Insurance Information – Copies of Front and Back of each card will be attached by our Receptionist

Primary Insurance Company:______________________________________

Subscriber Name____Date of Birth_____________

Secondary Insurance Company:____________________________________

Subscriber Name ____Date of Birth_____________

RELEASE AND ASSIGNMENT, GUARANTEE OF PAYMENT AND PRIVATE HEALTH INFORMATION NOTICES

1. By signing below, I am authorizing this physician and practice's staff to treat me for my orthopaedic conditions.
2. I authorize the release of my medical information to treating or referring physicians.
3. I authorize the release of medical information to insurance companies or other pertinent parties to process payments.
4. I authorize and request payment of medical benefits directly to my physician.
5. I agree this authorization will cover all medical services rendered until such authorization is revoked by me in writing.
6. I authorize the use of a fax in order to submit medical information to pertinent parties.
7. I agree that a photocopy of this form may be used in lieu of the original.
8. I understand that I am financially responsible for any balance that is not covered by my insurance carrier after 60 days.
9. I understand that the HIPAA Privacy Notice is posted, and I may have a copy if I request it.

From time to time, our doctors or staff may need to reach a patient directly concerning an appointment, test results, pathology reports, or medical information. It is at the patient's discretion when and with whom we share this information. This is due to HIPPA (Health Insurance Portability and Accountability Act of 1996).
I authorize Bayside Orthopaedic & Rehabilitation Center physicians and staff to release information concerning me to whomever I have listed below:

___ Myself only ___My answering machine ___Those listed below

1. Name___________________________________Phone #______________________
2. Name___________________________________Phone #______________________

Patient/Parent Signature____________________________________Date____________________