Patient Information

Thank you for filling out completely and welcome to Premier

Name _______________ **SS#** ___________________

Home Address
____
____
____
____
Birth Date ___________

Home Phone - _______________
Work Phone - _______________
Cell Phone - _______________
Emergency contact ______________
Emergency phone _______________
Pharmacy phone # _______________

Referring Physician ____________________________**Phone** __________________
Address _______________________________________
Primary Care Physician ___________________________ **Phone**_________________
Insurance Carrier _____________________**Policy #** _________________________
Policyholder ________________________
Date of Birth of Subscriber _______________**SS# of PolicyHolder** ______________

Consent to Treatment:

I authorize the Physicians and other medical providers of Premier Orthopaedics and Sports & Spine Rehabilitation to render treatment for my visits to this practice.

Patient Signature _________________________ Date __________________

Representative________________________

Personal Representative on behalf of a minor or otherwise not competent to give consent

Authorization For Release of Information and Direct Payment to the Doctor

Direct Payment: I authorize and direct my Insurance Carriers to make payment for medical or surgical treatment and injections and supplies directly to Premier Orthopaedics & Sports Medicine Associates. I hereby authorize the submission of all information necessary to complete this claim. These authorizations shall be effective for myself and my dependents. I agree that a copy of this authorization shall be as valid as the original.

MEDICARE and MEDIGAP: I request that payment of authorized MEDICARE AND MEDIGAP benefits be made either to me or on my behalf to the physician named above for services furnished by the physician. I authorize and holder of medical information about me to release to the Health Care Financing Administration and its agents to my MEDIGAP insurer and information needed to determined these benefits payable for the related services.

I also understand and I agree that I am responsible for payment of all charges not fully paid by my insurance.

Patient ____________________________________ Date _______________

Personal Representative (if applicable) _________________________________