

ORTHOPAEDIC Specialists of the Carolinas, P.A.

H K I L Cre Ko J R M Dbt EP OB Cra DP Hw La Ca Ch B Y S SP

TIME OF ARRIVAL _____
TIME OF APPT. _____
PAPERWORK RETURN _____

Please Print

Patient Information

PATIENT'S LAST NAME	FIRST NAME	MIDDLE/MAIDEN	CHART#		
SEX	BIRTH DATE	AGE	SOCIAL SECURITY #	CELL PHONE#	PRIMARY PHONE#
MAILING ADDRESS	CITY	STATE	ZIP CODE		
PHYSICAL ADDRESS IF PO BOX	EMAIL ADDRESS	COUNTY			
EMPLOYED BY	EMPLOYER'S ADDRESS	WORK PHONE #	EXT.		
SPOUSE'S NAME	BIRTH DATE	SPOUSE'S SS#	SPOUSE EMPLOYED BY	SPOUSE'S WORK PHONE #	
REFERRING DOCTOR	ADDRESS	FAMILY DOCTOR	ADDRESS		

LOCAL EMERGENCY CONTACT:
(NOT LIVING WITH YOU)

NAME	RELATIONSHIP	PHONE #
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RACE: American Indian Alaska Native Asian Black or African America Native Hawaiian or other Pacific Islander White

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

Insurance Information

PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.		
POLICY NO.	POLICY HOLDER	POLICY NO.	POLICY HOLDER
BIRTH DATE	SOCIAL SECURITY#	BIRTH DATE	SOCIAL SECURITY #
WILL YOU BE FILING WORKERS COMP? YES NO	OCCUPATION		
DID YOU HAVE AN ACCIDENT? YES NO	DATE OF INJURY/ONSET		

Responsible For Account

FATHER'S NAME	FATHER'S SOCIAL SECURITY NUMBER	BIRTH DATE	HOME PHONE #
FATHER'S ADDRESS	FATHER EMPLOYED BY	WORK PHONE #	EXT.
MOTHER'S NAME	MOTHER'S SOCIAL SECURITY NUMBER	BIRTH DATE	HOME PHONE #
MOTHER'S ADDRESS	MOTHER EMPLOYED BY	WORK PHONE #	EXT.

MEDICARE AUTHORIZATION:

I request that payment of authorized medicare benefits be made either to me or on my behalf to Orthopaedic Specialists of the Carolinas, P.A. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents to determine these benefits or benefits for related services.

_____(Seal) _____
SIGNATURE OF PATIENT/GUARDIAN DATE

AUTHORIZATION TO RELEASE INFORMATION AND BENEFITS TO PHYSICIAN:

I hereby authorize Orthopaedic Specialists of the Carolinas, P.A. to release any medical information to the Insurance company(s) I designate and authorize payment directly to Orthopaedic Specialists of the Carolinas, P.A. of any benefits payable to me for services rendered.

I understand that regardless of any insurance coverage applicable, I am responsible for any charges incurred in treatment.

I also understand that I will be responsible for all charges incurred in any collection efforts by OSC.

_____(Seal) _____
SIGNATURE OF PATIENT/PARENT OR GUARDIAN DATE