

# TAMPA ORTHOPAEDIC & SPORTS MEDICINE

## PATIENT INFO PLEASE PRINT

PATIENT NAME: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_  
 GUARDIAN: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
 HOME ADDRESS: \_\_\_\_\_ APT. # \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 HOME PHONE: ( ) \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ RACE: \_\_\_\_\_  
 EMPLOYER: \_\_\_\_\_ BUSINESS PHONE: ( ) \_\_\_\_\_  
 MARITAL STATUS: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_  
 HAVE YOU BEEN IN THIS OFFICE BEFORE  YES  NO

REFERRING PHYSICIAN: \_\_\_\_\_ PRIMARY PHYSICIAN: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
 CITY, STATE, ZIP: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
 TELEPHONE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
 IN CASE OF EMERGENCY: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
 FULL NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 RESIDENCE ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 DATE OF ACCIDENT \_\_\_\_\_

### PRIMARY INSURANCE COMPANY

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY, STATE ZIP: \_\_\_\_\_  
 PHONE #: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_  
 GROUP NUMBER: \_\_\_\_\_  
 POLICY HOLDER'S NAME: \_\_\_\_\_  
 S.S.# \_\_\_\_\_ D.O.B. \_\_\_\_\_

### SECONDARY INSURANCE COMPANY

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY, STATE, ZIP: \_\_\_\_\_  
 PHONE #: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_  
 GROUP NUMBER: \_\_\_\_\_  
 POLICY HOLDER'S NAME: \_\_\_\_\_  
 S.S.# \_\_\_\_\_ D.O.B. \_\_\_\_\_

INSURANCE INFORMATION IS THIS INJURY RELATED TO AN AUTOMOBILE ACCIDENT?  YES  NO  
 IS THIS AN "ON THE JOB" INJURY?  YES  NO (IF SO, DATE OF ACCIDENT) \_\_\_\_\_  
 PATIENT WHICH METHOD OF PAYMENT DO YOU CHOOSE FOR TODAY'S VISIT?  
 CASH  CHECK  MASTERCARD  VISA  AMERICAN EXPRESS  WORK COMP.  MEDICARE

### FINANCIAL INFORMATION

Patients who carry any form of medical insurance should know that all services furnished are charged directly to the patient and he or she is responsible for payment. We will prepare forms to assist in making collections from your primary insurance company and will credit such collections to your account. You will also be expected to pay any benefit proceeds from your insurance to this office. However, we cannot render services on the assumption that your charges will be paid solely by your insurance. Most misunderstandings about insurance can be avoided if you understand what your policy provides. Many insurance companies pay according to a schedule of benefits that is based on various criteria. This office charges fees, which are reasonable in this community. Not all insurance will pay 100% of our charges. The patient (and/or spouse/guarantor) is responsible to pay all sums unpaid by insurance. If it becomes necessary to collect any sum due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not. The patient authorizes the release of any information acquired in the course of treatment as necessary to file insurance claims.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

### MEDICARE B SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me; to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or related Medicare claim. I permit a copy of the authorization to be used in place of original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that this signature is a lifetime signature.

Date Signed \_\_\_\_\_ Patient \_\_\_\_\_