

Cape Cod Sports Medicine, Inc.

Patient Information

* Is injury work related? Y / N If so, have you reported it to your employer? Y / N

* Is injury related to a motor vehicle accident? Y / N

NAME _____ BIRTHDATE _____

SEX M F SOCIAL SECURITY NUMBER _____ MARITAL STATUS S M D W

MAILING ADDRESS _____

TOWN _____ STATE _____ ZIP CODE _____

TELEPHONE (H) _____ (W) _____ (CELL) _____

PRIMARY PHYSICIAN NAME _____ PHONE _____

OCCUPATION _____ EMPLOYER _____

RESPONSIBLE PARTY _____ SSN _____ DOB _____

ADDRESS _____ RELATIONSHIP TO PATIENT _____

PLEASE NOTE: ALL BILLS ARE THE PATIENT'S RESPONSIBILITY. PLEASE SUPPLY ALL INSURANCE INFORMATION. IF INCOMPLETE, WE CANNOT BILL. WE WILL BILL YOUR INSURANCE ONCE AS A COURTESY TO YOU.

PRIMARY INSURANCE CO. _____ ID # _____

SUBSCRIBER NAME _____ SSN _____ DOB _____

SECONDARY INSURANCE CO _____ ID # _____

SUBSCRIBER NAME _____ SSN _____ DOB _____

In some cases, it is helpful for the physician to know whether or not you live independently or if you are the primary caregiver for a family member. This is important in determining some patient's post surgical and/or rehabilitation needs.

Do you live alone? Y / N

Are you a primary caregiver? Y / N

SPOUSE/CONTACT (PARENT/GUARDIAN IF MINOR) _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

*****AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS*****

I HEREBY AUTHORIZE PAYMENT FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, RESULTING FROM THIS ILLNESS, INJURY OR ACCIDENT TO CAPE COD SPORTS MEDICINE, DONALD O'MALLEY, MD. I ALSO AUTHORIZE CAPE COD SPORTS MEDICINE AND ABOVE MENTIONED PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY PHYSICIAN AND TO THE APPROPRIATE INSURANCE CARRIERS.

SIGNATURE _____ DATE _____