

**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 \_\_\_\_\_