EAST COAST ORTHOPAEDICS

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LIABILITY PATIENT INFORMATION

PLEASE PRINT CLEARLY

PATIENT'S NAME _____
(LAST) (FIRST) (MIDDLE INITIAL)

STREET _____ APARTMENT#_____

CITY_____ STATE _____ ZIP _____

HOME PHONE ( )_____ CELL ( ) _____

AGE _____ DATE OF BIRTH _____ SEX _____ MARITAL STATUS _____

SOCIAL SECURITY # _____ EMAIL: _____

WHO IS YOUR PRIMARY DOCTOR? _____ CITY: _____

PHONE ( ) _____ FAX ( ) _____

PATIENT'S EMPLOYER _____ PHONE ( ) _____

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE ( ) _____

PARTICULARS REGARDING ACCIDENT

(1) DATE OF ACCIDENT _____ STATE OF ACCIDENT _____

(2) SEATING OF PATIENT IN AUTO WHEN ACCIDENT OCCURRED _____

(3) EXACT PARTICULARS AS TO HOW PATIENT'S AUTO WAS HIT _____

_____

_____

(4) WERE YOU THROWN FROM THE CAR? YES _____ NO _____ (5) DID YOU LOSE CONSCIOUSNESS? YES_____ NO_____

(6) IMMEDIATE AWARENESS OF INJURIES YES _____ NO _____ (7) DID YOU GO TO THE HOSPITAL? YES_____ NO_____

ATTORNEY'S NAME _____

PHONE ( ) _____ FAX ( ) _____

ATTORNEY'S ADDRESS _____

CITY _____ STATE _____ ZIP_____

PLEASE PROVIDE A PHOTO ID AND ALL INSURANCE CARDS.

I UNDERSTAND THAT CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES ARE MY RESPONSIBILITY AND ARE DUE AT EACH VISIT.

I understand that regardless of my insurance coverage, any charges that are not covered during my treatment are my responsibility and are due upon receipt of statements.

I authorize East Coast Orthopaedics to release information regarding my condition to my insurance company, referring physician or attorney. I authorize all diagnostic facilities and other treating physician's offices to release my records to East Coast Orthopaedics.

I authorize my insurance benefits to be paid directly to the health care provider.

SIGNATURE _____ **DATE** _____