

# 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** \_\_\_\_\_