EAST COAST ORTHOPAEDICS

Bruce E. Janke, M.D. Steven E. Naide, M.D. John P. Malloy, D.O.

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: _____

WHO REFERRED YOU TO OUR OFFICE? _____

IS YOUR PROBLEM RELATED TO AN AUTO ACCIDENT? _____
(if yes, please give date of accident) _____

IS YOUR PROBLEM RELATED TO A WORK INJURY? _____
(if yes, please give date of accident) _____

PATIENT'S EMPLOYER _____

EMPLOYER ADDRESS _____

EMPLOYER PHONE ( ) _____OCCUPATION _____

EMERGENCY CONTACT _____

RELATIONSHIP TO PATIENT _____PHONE ( ) _____

SPOUSE'S NAME (IF APPLICABLE) _____ PHONE ( )_____

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.

SIGNATURE _____ DATE _____

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COMPLETE THIS SECTION ONLY IF THE PATIENT IS A MINOR

Insurance Company: _____
Policy holder's name: _____
Policy holder's date of birth: _____/_____/_____ SS# _____

SIGNATURE _____ DATE _____