

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