ORTHOPAEDIC ASSOCIATES

Patient Information

Patient Name

Social Security Number

Home Telephone # _____
Work Telephone # _____
Cell Telephone # _____
E-Mail Address (please print):
_____

Address

City, State & Zip Code

FOR MEDICARE PATIENTS ONLY
Do you currently reside in a Skilled Nursing Facility?
☐ Yes ☐ No

Patient Sex _____

Date of Birth _____ **Age** _____

☐ **Married** ☐ **Single** ☐ **Other**

Spouse/Partner Name:

Employment / Student Status:
☐ Full time employed ☐ Full time student
☐ Part time employed ☐ Part time student
☐ Unemployed
☐ Retired

Employer Name & Address
_____
_____
Occupation:

Referring Physician Name

Family Physician Name

Patient Smoking Status
☐ Current everyday smoker ☐ Heavy tobacco smoker
☐ Current someday smoker ☐ Light tobacco smoker
☐ Former smoker ☐ Never smoker
☐ Unknown if ever smoker
☐ Smoker, current status unknown

If you are a current smoker, what was your start date? _____
How many packs do you smoke a day? _____
If you are a former smoker, what was your quit date? _____

Ethnicity of Patient
☐ Hispanic Origin ☐ Unknown
☐ Non Hispanic Origin ☐ Declined to answer

Race of Patient
☐ American Indian / Alaskan Native
☐ Asian
☐ Black / African American
☐ Native Hawaiian / Other Pacific Islander
☐ White
☐ Unknown
☐ Declined to answer

Preferred Language of Patient
☐ English ☐ Spanish
☐ Other _____

In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

Financially Responsible Person (if different from above)

Full Name
_____
Address
_____
City, State & Zip Code
_____

Date of Birth _____

Employer Name _____

Social Security Number # _____

Home Telephone # _____

Work Telephone # _____

Cell Telephone # _____

Relationship to the Patient (check one)
☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Insurance Company Information

Primary Insurance Company Name		**Secondary Insurance Company Name**	
Address, City, State & Zip		**Address, City, State & Zip**	
Policy Holder	**Date of Birth**	**Policy Holder**	**Date of Birth**
Policy Holder Employer	**Policy Holder SSN**	**Policy Holder Employer**	**Policy Holder SSN**
Policy Number	**Group Number**	**Policy Number**	**Group Number**
Relationship to the Patient (check one)		**Relationship to the Patient (check one)**	
☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

MEDICATION HISTORY

I agree that Orthopaedic Associates of Southern Delaware, P.A., may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature of Patient or Guardian _____ Date _____

Preferred Pharmacy:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Mail Order:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Orthopaedic Associates of Southern Delaware, P.A., for all services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature of Patient or Guardian _____ Date _____

MEDICARE PATIENTS

If you are covered by Medicare, please read and sign the following: In Medicare cases, Orthopaedic Associates of Southern Delaware, P.A., agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature of Patient or Guardian _____ Date _____

MISSED APPOINTMENTS

I understand that if I miss an appointment or cancel an appointment less than 24 hours before the appointment time, I will be responsible for paying a **$35.00 fee**. If there is inclement weather or other extenuating circumstances, exceptions may be made.

I understand that Orthopaedic Associates of Southern Delaware, P.A., is not able to bill my insurance company for missed appointments and that I will be responsible for the **$35.00 charge**.

Signature of Patient or Guardian _____ Date _____