ORTHOPAEDIC & SPORTS MEDICINE CENTER OF MIAMI

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PATIENT INFORMATION

Patient Name: _____ **Age:** _____

Address:_____ **City:** _____ **State:**_____ **Zip Code:**_____

Home Phone: _____ **Cell:** _____ **Work Phone:** _____ **Ext.** _____

Please Circle: Male Female **Please Circle:** Married Single Widowed

Date of Birth: _____ **Social Security#** _____ **E-mail:** _____

Is this an accident related injury? Yes No **Did this accident happen at:** Home Work Auto School Other

Date of Accident_____ **Description of Accident:** _____

_____

Were you treated at an emergency facility? Yes No

Which facility: _____ **Treating Physician:** _____

Were X-rays or other tests done? Yes No **Please Describe:** _____

Personal or Primary Care Physician Name_____

Whom referred you to our office? _____

Patients Employer: _____ **Address:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:**_____

IF THE PATIENT IS A MINOR THIS SECTION MUST BE COMPLETED BY ACCOMPANIED GUARDIAN

Mothers Name: _____ **SSN:** _____ **DOB:** _____

Fathers Name: _____ **SSN:** _____ **DOB:** _____

Insurance Information: (PLEASE PRESENT YOUR ID CARD TO THE FRONT RECEPTIONIST)

 # 1- Insurance Company Name: _____ **ID:** _____

Insured Name: _____ **DOB:** _____ **Group:** _____

Authorization: _____ **Visits:** _____ **Expires:** _____

#2- Insurance Company Name: _____ **ID:** _____

Insured Name: _____ **DOB:** _____ **Group:** _____

Authorization: _____ **Visits:** _____ **Expires:** _____

I hereby authorize payment directly to Orthopaedic & Sport Medicine Center of Miami, P.A. and/or Daniel G. Kalbac, M.D. for benefits due to me from my insurance company payable to me. I further authorize the release of any medical information required by my insurance carriers. A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefit either to myself or to the party who accepts assignment I understand that I am financially responsible for charges not covered by this authorization.

I acknowledge receipt of the HIPAA – Summary of Notice of Privacy Practices of Orthopaedic & Sport Medicine Center of Miami, P.A. and have signed the Acknowledgement of Receipt

I hereby understand and receive Summary of Notice and HIPAA compliance. **Initial:** _____

Signature: _____ **Date:** _____