STEINGART ORTHOPEDICS, P.C.

PATIENT INFORMATION SHEET

ACCT # _____ Today's Date_____

** *Please Print & Complete Everything

Patient's Full Name_____Birth Date_____Age_____

Current Address_____
Street City State Zip

Email_____ Primary Phone_____Secondary Phone_____

Marital Status: Single ____ Married____ Other_____ SS#_____M___F___

Race_____ Language_____

Patient's Employer/Parent_____Occupation_____

Address_____Phone_____
Street City State Zip Zip

Parent or Spouse's Full Name_____SS#_____Birth Date_____

Parent or Spouse's Employer_____Occupation_____

Address_____Phon_____
Street City State Zip

Primary Care/Referring Physician_____

RELATIVE WHOM WE MAY CONTACT IN THE EVENT OF AN EMERGENCY:

Name_____Phone_____Relationship_____

Area of Complaint?_____

Sports Injury? __Yes __No Work Injury? __Yes __No Auto Accident? __Yes __No School Injury? __Yes __No

Date of Injury:_____ Student? __Yes __No If Yes, _____Full-Time ____Part-Time

Smoker? __Yes __No Medication Allergies_____Dominant Hand? ___Right ___Left

Insurance Information

PRIMARY INSURANCE

Insured Party_____DOB_____Relationship_____

Primary Insurance_____Effective Date_____

Address_____
Street City State Zip

Policy #_____ Group# _____Copay$_____

Phone #_____ Deductible Amt$_____ Met?___Yes___No Amount Left$_____

SECONDARY INSURANCE

Insured Party_____DOB_____Relationship_____

Secondary Insurance_____Effective Date_____

Address_____
Street City State Zip

Policy #_____ Group# _____Copay$_____

Phone #_____ Deductible Amt$_____ Met?___Yes___No Amount Left$_____

[OVER]

Patient Name _____ DOB _____ Account # _____

AUTHORIZATION

I hereby authorize STEINGART ORTHOPEDICS to release any information acquired in the course of my examination or treatment.

I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical care and treatment to STEINGART ORTHOPEDICS.

I hereby authorize photocopies of this form and my signature to be as valid as the original.

I hereby authorize payment directly to STEINGART ORTHOPEDICS for the surgical and/ or medical benefit, if any, otherwise payable to me under terms of my insurance.

If eligibility of insurance cannot be verified, or if deductible has not been met, I understand that I will be responsible for the cost of all medical services rendered.

I agree to pay any collection costs and/ or attorney fees as may be required to effect collection of charges incurred.

Date_____ Signature _____

CONSENT FOR TREATMENT OF MINOR

I hereby give my consent for the attending physician to render medical treatment, as deemed necessary to my child.

_____
Child's name

_____ _____
Signature of Parent/Guardian Date

_____
Witness

AUTHORIZATION RECEIVED BY PHONE

Parent or Guardian: _____

Witness: _____

Witness: _____

STEINGART ORTHOPEDICS, P.C.

MICHAEL A. STEINGART, D.O.

ORTHOPEDIC SURGERY* BOARD CERTIFIED

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