ISLAND ORTHOPEDICS AND SPORTS MEDICINE, P.C.

660 BROADWAY MASSAPEQUA, NY 11758 (516)-798-0111

www.iosmpc.com

PATIENT INFORMATION FOR MEDICAL RECORDS (Please Print)

LAST NAME	FIRST NAME	TODAY'S DATE

HOME ADDRESS STREET	CITY	STATE	ZIP	HOME TELEPHONE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX M ☐ F ☐	CELL PHONE

PATIENT EMPLOYER	OCCUPATION

EMPLOYER ADDRESS STREET	CITY	STATE	ZIP	BUSINESS PHONE

INSUREDS NAME (IF NOT PATIENT)	REFERRED BY

EMPLOYER ADDRESS STREET	CITY	STATE	ZIP	BUSINESS PHONE

IN CASE OF EMERGENCY CONTACT STREET	CITY	STATE	ZIP	TELEPHONE

EMAIL ADDRESS

IF YOU ARE NOT THE POLICY HOLDER YOU MUST COMPLETE THIS SECTION

POLICY HOLDER LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

RELATION TO PATIENT	STREET ADDRESS CITY	STATE	ZIP	TELEPHONE

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	ADDRESS

POLICY HOLDER SELF ☐ SPOUSE ☐ PARENT ☐	YOUR ID NUMBER	GROUP NUMBER	COPAY AMOUNT

SECONDARY INSURANCE COMPANY	ADDRESS

POLICY HOLDER SELF ☐ SPOUSE ☐ PARENT ☐	YOUR ID NUMBER	GROUP NUMBER

PLEASE SIGN BELOW AND RETURN TO RECEPTIONIST

Charles B. Goodwin, M.D. has made its notice of Privacy Practices for Protected Health Information known to me.

Patient Signature: _____ Date _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or other Insurance company benefits be made either to me or on my behalf to Island Orthopaedics and Sports Medicine. P.C. for any services furnished me by that provider who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services(CMS) or its Intermediaries or carrier or any other insurance company any information needed for this or a related claim.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the indicated insurance company. I am aware that if I have a managed care plan, I will be held accountable for payment if I did not obtain a referral for my visit. I understand that I will be held responsible for payment of noncovered service by my medical insurance company. In the event that any action Is brought to collection, I agree to pay any collection costs and/or attorney fees which is 33% after 90 days past due. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services, I am also aware that payment for services and/or co-payment are due when services are rendered.

Signature _____ **Date** _____

REV 3/07