# We appreciate your cooperation in filling out this form.

Please give the Receptionist your insurance card to copy for our record

# **PATIENT INFORMATION**

Patient name:				
Home address:				
City, State, Zip:				
Home Phone:			Work Phone:	
Email Address:			Cell Phone:	
Date of Birth:			Age:	
Social Security #:			-	
Occupation:				
Employer's name:				
Employer's address:				
Person to notify in case of emergency:				
Relation to patient:	Spouse	Mother	Father	Other
Phone:			_	
REFERRAL SOUR	CE			
Patient Referred by:	Physician	Friend	Other	
Referring Physician:				
Address:				
Phone:			_	
Is this a second surgic	cal opinion? Yes		No	
Would Like a report s	ent to your Referrin	ng Physician	: Yes	No
Managed Care Patient	ts:			
Is this your Primary c	are Physician: Yes		No If No, p	lease provide us with the following:
Primary Care Physicia	an:			
Address:				

# PRIMARY INSURANCE

Policyholder is:	Patient	Spouse	Parent	Managed Care? Yes	No		
Policyholder name:				DOB			
Insurance company:							
Insurance address:							
			Pł	none:			
Certificate number:			Group:	Plan:			
SECONDARY INSUR	RANCE						
Policyholder is:	Patient	Spouse	Parent	Managed Care? Yes	No		
Policyholder name:				DOB			
Home address:							
Home Phone:			Wo	rk Phone:			
Social Security #:	Occupation:						
Employer's name:							
Employer's address:							
Insurance company:							
Insurance address:							
			P	hone #			
Certificate number:		Group: Plan:					
COMPENSATION / N	NO FAULT IN	FORMATION (V	Vork Related or 1	<u>Motor Vehicle accident)</u>			
Carrier Name:							
Carrier Address:							
City, State, Zip:			Pł	none #			
Contact Person:							
WCB Case #			Carrier Ca	ase #			
Date of Accident:				Comp or No Fa	ult		
Comments:							

PATIENT MEDICAL	<u>HISTORY</u>			
Allergies:				
Current Medications:				
Please circle any of the	following condi	itions you have now, or	r have has in the past:	
Bleeding Problems	Cancer	Tuberculosis	Kidney Disease	Stomach Ulcer
High Blood Pressure	Goiter	Skin Problems	Heart Disease	Rheumatic Fever
Thyroid Disease	Diabetes	Gout	Bladder Disease	Rheumatoid Arthritis
List prior surgeries of a	ny kind includir	ng dates and complicati	ions:	
Please describe, with da	ates, any serious	injuries:		
Please note the reason f	for today's visit:			
Side of body affected:	Right Le	eft Both	I am Righthanded	I am Lefthanded
-	-		is treatment of this problem:	
rease provide the ham	e, address, and e	ate of visit for previou	s treatment of this problem.	
Please provide the date	of injury, or the	date you first noticed	this problem:	
Please provide any add	itional medical i	nformation relevant to	your current problem:	

#### Patient's Name

(First) (MI) (Last)

#### **Claims Authorization**

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.

# Assignment of Benefits – Private and Federal (Medicare)

I authorize payments of medical and surgical benefits, including Medicare benefits; to be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care financing administration and its agents any information needed to determine these benefits payable for related services.

### **Litigation Disclaimer**

It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical record and X ray in the possession and control of this office, pursuant to receipt of a properly notarized consent for medical information, requested by the patient or his/her legal guardian, and upon payment of the usual fee.

#### **Radiological films**

Radiology films are the property of the patient. Charles B. Goodwin, MD, as a courtesy, will store all films. We will release films only to the patient or representative of the patient. Patient's films will not be released to an attorney.

# Patient/Relative or Guardian:

(Signature)

(Date)

(Print Name)

(Acct. #)

(Relationship, if signed by person other than patient)

Photocopy or fax of this form shall be considered as effective and valid as the original