David A. Wang, MD
Primary Care Sports Medicine Physician

UPDATE

PRINT NAME: ____
ADDRESS: ____
DOB: ___________AGE:_____SEX:___SS#_________________________
HOME: __________MOBILE PHONE: __________________________
WORK: __________FAX:______________________________________

INSURANCE INFORMATION
Did you injure yourself at work or is this injury a result of a car accident Y/ N?
If so please get the proper forms from our Front Desk.

Primary
Insurance Name: ___________________ **Policy Holder**: ________________________

ID #: ____________________________ Group #: ____________________________

Address: __________________________ Policy Holder DOB: ___________________
City:_____________State:_____Zip_____
Insurance Phone: ____________________ **Relationship to Patient**: _________________

Secondary
Insurance Name: ____________________ **Policy Holder**: _________________________

ID #: ______________________________ Group #: _____________________________

Address: ___________________________ Policy Holder DOB: ____________________
City: _____________State:_____Zip:_____
Insurance Phone: _____________________ **Relationship to Patient**: _______________

Assignment and Release of Information: I certify that the information given by me is correct. I hereby authorize the release of any information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to the doctor and understand that in the absence of accepted insurance coverage, I/legal guardian are responsible for payment in full for services rendered.
Medicare Patients- I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductible on all services.

X_________________________________ **Date**______________________________

HOSPITAL FOR SPECIAL SURGERY — WHERE THE WORLD COMES TO GET BACK IN THE GAME

EMERGENCY CONTACT

PRINT NAME: ____ SEX: _____________
RELATIONSHIP TO PATIENT: _________________ D.O.B._________________
ADDRESS: ____
PHONE: ____________________ALTERNATE:______________________________
EMPLOYER/SCHOOL: ____
OCCUPATION: ____
CIRCLE *FULL-TIME *PART-TIME *STUDENT *RETIRED DATE_______
ADDRESS: ____
EMPLOYER PHONE: ____
REFERRED BY: ____

PHARMACY NAME AND NUMBER:_________________________________
ALLERGIES: ____
CURRENT MEDICATIONS: ____

ePrescribing is submitting a prescription to your pharmacy through the internet. The ability to ePrescribe is an important element in improving the quality of patient care by reducing medication errors and enhancing patient safety.
Through ePrescribing your physician may also obtain ***medication history*** (information about the medications you are already taking or have taken within the past year) when applicable for the purpose of coordinating your treatment. Having an accurate list of your medications is critical to providing good medical care.

☐ **YES,** I allow my physician to obtain ***medication history*** (check box)

☐ **NO,** I do not allow my physician to obtain ***medication history*** (check box)

Note: while you may not allow us to obtain your medication history, we may still submit an ePrescription. Alternatively, we may also provide a paper prescription. If I choose not to allow my physician to access my medication history through ePrescribing, I understand that my physician may not be aware of all medications prescribed by others. Therefore, I am solely responsible for informing my physician about medications I have been prescribed by other physicians or prescribers. I acknowledge and accept any and all risks, including the risk of adverse drug events, associated with my physician not having access to my medication history through ePrescribing.By signing below, I confirm that I have read and understand all of the above, that I have had the chance to ask questions and all of my questions have been answered to my satisfaction, and that I am eligible to sign this form on behalf of myself/the patient.

X___________________________________ **Date**________________________________