ORTHOPAEDIC CARE SPECIALISTS
733 US HIGHWAY ONE
NORTH PALM BEACH, FL 33408

NAME ____

STREET ______________________ APT ______________________

CITY______________________ STATE ________ ZIP ____________

DO YOU HAVE AN NORTHERN ADDRESS? _____YES_____NO (if so please provide on reverse side)

AGE ________________SEX________DATE OF BIRTH________________

HOME PHONE______________CELL__________WORK PHONE____________

EMAIL ADDRESS ____

PHARMACY NAME __________________ PHONE ______________________

SOCIAL SECURITY __________________ MARITAL STATUS: M S W D

SPOUSE'S NAME __________________ SPOUSE DATE OF BIRTH ____________

NAME OF EMPLOYER____

IS INJURY A RESULT OF:

MOTOR VEHICLE ACCIDENT? DATE ______________

WORK RELATED ACCIDENT? DATE ______________

OTHER ACCIDENT? DATE ______________

(Please describe)

DO YOU HAVE MEDICAL INSURANCE? ________________________________

(Please provide us with your card)

WHO IS YOUR MEDICAL DOCTOR? ________________________________

MEDIGAP AUTHORIZATION

(FOR MEDICARE PATIENTS ONLY)

I request that payment of authorized MEDIGAP benefits be made on my behalf to ORTHOPAEDIC CARE SPECIALISTS for services furnished to me. I authorize any holder of medical information about me to release to my Medigap insurance company any information needed to determine these benefits or the benefits payable for related services.

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Signature Date

LIFETIME AUTHORIZATION

(FOR ALL PATIENTS)

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim.
I understand that I am financially responsible for all charges to the extent permissible under law.

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Signature Date