

ORTHOPAEDIC MEDICAL GROUP AND ATHLETIC REHABILITATION CENTER, INC.

PATIENT: _____ **DATE:** _____
Last First Initial

HOME ADDRESS: _____
Street City State Zip Code

PHONE: _____ **CELL:** _____ **DATE OF BIRTH:** _____ **AGE:** _____ **SEX:** M F

SOC. SEC. NO.: _____ **DRIVER'S LICENSE #:** _____

EMPLOYER NAME: _____ **ADDRESS:** _____
Street City State Zip

TELEPHONE #: _____ **OCCUPATION:** _____

NAME OF SPOUSE OR RESPONSIBLE PARTY: _____

EMPLOYER NAME: _____ **ADDRESS:** _____
Street City State Zip

TELEPHONE#: _____ **OCCUPATION:** _____

IN CASE OF EMERGENCY, CONTACT: _____ **PHONE:** _____

REFERRING PHYSICIAN: _____ **ADDRESS:** _____

PRIMARY INSURANCE: _____ **SUBSCRIBER'S NAME:** _____

ID #: _____ **GROUP #:** _____

SECONDARY INSURANCE: _____ **SUBSCRIBER'S NAME:** _____

ID #: _____ **GROUP #:** _____

IS THIS CONDITION DUE TO AN ACCIDENT: YES NO / AUTO WORK OTHER **DATE OF INJURY:** _____

DESCRIBE HOW ACCIDENT HAPPENED: _____

IN ORDER TO SUBMIT AT CLAIM FOR PAYMENT TO US FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER.

MEDICARE

NAME OF BENEFICIARY: _____

I request that payment of authorized Medicare benefits be made to me or on my behalf to ORTHOPAEDIC MEDICAL GROUP AND ATHLETIC REHABILITATION CENTER, for service furnished me by that physician. 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 service. I hereby authorize Medicare to furnish the above named doctor any information regarding my Medicare claims under title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize the 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.**

SIGNATURE

DATE

The undersigned hereby consents to the care and treatment now and in the future of _____
Patient name
by Orthopaedic Medical Group and Athletic Rehabilitation Center, Inc.

Thomas Bryan, M.D., Carlos Lugon, M.D., Vic A. Osborne, M.D., Kee Wong, M.D., Arthur H. Osborne, M.D., Patrick Duke, P.A.-C., Bryan J. Block, P.A.- C.

Patient Signature (or Signature of Parent or Guardian)

Date