Madison Avenue Orthopaedic Associates, P.C.

PATIENT INFORMATION FORM

PLEASE PRINT — ALL AREAS MUST BE COMPLETED

PATIENT INFORMATION

Last Name	First Name	Age

If Minor, In Care Of:

Address	City	State	Zip Code

Home Phone #	Date of Birth	Marital Status ☐ Single ☐ Married ☐ Other	Social Security #	Sex ☐ M ☐ F

Employed? ☐ Yes ☐ No	Employer's Name	Work Phone #

Address	City	State	Zip Code	Employee ID #

Referring Doctor's Name	Address	Phone #

Is this a work related accident? ☐ YES ☐ NO If so, give date of accident::

Is this a motor vehicle accident? ☐ YES ☐ NO If so, give date of accident:

INSURANCE INFORMATION (Get this information from your insurance ID card or claim form)

PRIMARY INSURANCE COMPANY	Insurance ID #	Group #	SS #

Insurance Company Address	City	State	Zip Code

Name of Insured Party	Sex ☐ M ☐ F	Date of Birth

Address of Insured Party	Home Phone #

Name of Insured's Employer	Employer Insurance Plan? ☐ Yes ☐ No

Relation to Patient (Please check one) ☐ HUSBAND ☐ WIFE ☐ PARENT ☐ OTHER

SECONDARY INSURANCE COMPANY	**Insurance ID #**	**Group #**

Insurance Company Address	City	State	Zip Code

Name of Insured Party	Sex ☐ M ☐ F	Date of Birth

Address of Insured Party	Home Phone #

Name of Insured's Employer	Employer Insurance Plan? ☐ Yes ☐ No

Relation to Patient (Please check one) ☐ HUSBAND ☐ WIFE ☐ PARENT ☐ OTHER

I verify the accuracy of aforementioned information and I authorize the release of information as provided on the reverse side of this page.

Signature **Date**

I am in agreement with the 'Authorization to Pay' and the 'Patient Responsibility to Pay' statements on the reverse side of this page.

Signature **Date**

I acknowledge that I have received the Notice of Patient Privacy Rights from Madison Avenue Orthopaedic Associates, PC.

Signature **Date**

The Physicians and Staff at Madison Avenue Orthopaedic Associates, PC, may discuss my care with the following people:

AUTHORIZATION FOR RELEASE OF MEDICAL BENEFITS
AND
PAYMENT AGREEMENT

PART ONE

***ALL PATIENTS (Including Medicare Patients) PLEASE READ AND SIGN

I verify the accuracy of the information provided on the Patient Demographic Sheet and authorize release of information necessary to process any claims. I also understand that Madison Avenue Orthopaedic Associates, P.C., may not participate with my insurance and I am therefore responsible for payment. If my insurance is one that this facility participates in, I request payment of claims directly to this facility. I understand that I am ultimately responsible for all services. Additionally, I will be responsible for all balances after insurance payments. I will work with the Doctor's office to have Compensation and/or No Fault claims paid to the Doctor, and I understand that all bills are my responsibility if not paid by the carrier.

___________________________________ _____________
Signature of Patient or Authorized Agent Date

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Print Name

PART TWO
MEDICARE SIGNATURE ON FILE

****ALL MEDICARE PATIENTS: PLEASE READ AND SIGN

I request that payment of authorized Medicare benefits be made to my physician for any services furnished me by the physician. I authorize Madison Avenue Orthopaedic Associates, P.C., to release what is needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration and its agents.

___________________________________ _____________
Signature of Patient or Authorized Agent Date

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Print Name