

FIRST STATE ORTHOPAEDICS



- | | | | | | | |
|--|--|---|--------------------------------------|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Dr. Jeremie Axe | <input type="checkbox"/> Dr. Michael Axe | <input type="checkbox"/> Dr. Bodenstab | <input type="checkbox"/> Dr. Brady | <input type="checkbox"/> Dr. Crain | <input type="checkbox"/> Dr. Ginsberg | <input type="checkbox"/> Dr. Gotha |
| <input type="checkbox"/> Dr. Handling | <input type="checkbox"/> Dr. Johnson | <input type="checkbox"/> Dr. Kahlon | <input type="checkbox"/> Dr. Leitman | <input type="checkbox"/> Dr. Manifold | <input type="checkbox"/> Dr. Mavrakakis | <input type="checkbox"/> Dr. Moran |
| <input type="checkbox"/> Dr. Newell | <input type="checkbox"/> Dr. Pan | <input type="checkbox"/> Dr. Pushkarewicz | <input type="checkbox"/> Dr. Rasis | <input type="checkbox"/> Dr. Rudin | <input type="checkbox"/> Dr. Smucker | <input type="checkbox"/> Dr. Sowa |
| <input type="checkbox"/> Dr. Straight | <input type="checkbox"/> Dr. Tooze | <input type="checkbox"/> Dr. Zaslavsky | | | | |

PATIENT INFORMATION

Name _____ (LAST) (FIRST) (MI)	Date of birth _____ <input type="checkbox"/> Male
Address _____	Age _____ <input type="checkbox"/> Female
Development _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
City/State/Zip _____	<input type="checkbox"/> Civil Union
Home phone () _____ Cell () _____	Relationship to responsible person _____
Family Doctor _____ Phone () _____	E-Mail: _____
Referring Dr. _____ Phone () _____	Occupation _____
How did you hear about us? _____	Employed by _____
Referring Attorney Name _____	Business Phone () _____

OPTIONAL INFORMATION

Preferred Language _____ Race _____ Ethnicity _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT)

Name _____ (LAST) (FIRST) (MI)	Relationship to Patient _____
Address _____	Occupation _____
Development _____	Employed by _____
City/State/Zip _____	Business Phone () _____
Home phone () _____	

INSURANCE INFORMATION

PRIMARY	
Subscriber's Name _____ (LAST) (FIRST) (MI)	Patient's I.D. No. _____
Insurance Co. Name _____	Group/Account No. _____
Insurance Co. Address _____	Relationship to Patient _____
City/State/Zip _____	Date of birth _____
	SS# TriCare or V.A. _____ Patient's Only
SECONDARY	
Subscriber's Name _____ (LAST) (FIRST) (MI)	Patient's I.D. No. _____
Insurance Co. Name _____	Group/Account No. _____
Insurance Co. Address _____	Relationship to Patient _____
City/State/Zip _____	Date of birth _____
	SS# TriCare or V.A. _____ Patient's Only

Box **Auto Accident** **Work Injury** **Personal Injury**

Insurance Co. Name _____	Date of Injury _____
Insurance Co. Address _____	State in which injury occurred: _____
City/State/Zip _____	Claim Number _____
Insurance Co. Phone () _____	(Complete the following if accidental injury)
Name of Adjuster _____	Where Accident Occurred: _____
Name of Attorney _____ Phone () _____	How Accident Occurred: _____

FIRST STATE ORTHOPAEDICS

WHO MAY WE TALK TO ABOUT YOUR CARE?

You may communicate with the following individuals about my care:

Name Relationship Phone Number

FIRST STATE SURGERY CENTER / SPINE CARE DELAWARE/FIRST STATE IMAGING CENTER

The First State Surgery Center and Spine Care Delaware and First State Imaging Center are owned and operated by Physicians of First State Orthopaedics. While our outpatient surgery centers are an appropriate site for your surgical procedure, there are other facilities in the area where such procedures could also be performed. There will be a separate facility fee for surgeries performed at First State Surgery Center or Spine Care Delaware as there would be from any other facility.

FIRST ASSISTANT AT SURGERY

First State Orthopaedics, P.A. employs board certified physician assistants who are trained to perform the duties of a first assistant at surgery and to assist in the office. Our billing to your insurance carrier may include a fee for the physician assistant.

FINANCIAL RESPONSIBILITY STATEMENT / INSURANCE ASSIGNMENT

Please refer to the financial policy. Separate attachment.

I AGREE TO THE ABOVE CONDITIONS

If the patient is a minor, the parent or legal guardian must sign

Signature of patient, parent or legal guardian Date

MEDICARE SIGNATURE ON FILE

" I request that payment of authorized Medicare benefits be made on my behalf to First State Orthopaedics, P.A., for any services furnished me by that physician's). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS), which oversees the Medicare program, and its agents any information needed to determine these benefits payable for related services."

Signed: Medicare Beneficiary Date

THE PATIENT / GUARANTOR IS RESPONSIBLE FOR ALL ACCOUNT BALANCES AFTER INSURANCE HAS PAID