



Bone and Joint Specialists

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PATIENT INFORMATION

DATE _____ EMAIL _____

LAST NAME _____ MIDDLE INITIAL _____ FIRST NAME _____ B'DATE: _____

AGE _____ SEX _____ SOCIAL SECURITY _____ HOME# _____ WORK/CELL# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

MARITAL STATUS _____ HEIGHT _____ WEIGHT _____

WHAT PROBLEM ARE YOU BEING SEEN FOR TODAY? (Please indicate right or left side) _____

DATE OF INJURY _____ PLACE OF INJURY (ex. Home/Work) _____

HOW DID INJURY OCCUR? _____ DATE X-RAYS TAKEN _____ PLACE X-RAYS TAKEN _____

IS THIS A SECOND OPINION ONLY? _____ WHO REFERRED YOU TO US? _____

WHO IS YOUR PRIMARY DOCTOR? _____ PRIMARY DOCTOR'S TELEPHONE# _____

ARE YOU PREGNANT? _____ PATIENT OCCUPATION _____ EMPLOYER _____

ALTERNATE or EMERGENCY CONTACT NAME _____ RELATION _____ PHONE# _____

SPOUSE/PARENT (If Minor) _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO IF SO WHAT _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ SUBSCRIBER NAME: _____

SUBSCRIBER EMPLOYER: _____ SUBSCRIBER S.S.#: _____

SUBSCRIBERS BIRTHDATE: ____ / ____ / ____ SECONDARY INSURANCE: _____ SUBSCRIBER: _____

IF BOTH PARENTS HAVE COVERAGE ON CHILD, WE NEED MOM'S BIRTHDATE: ____ / ____ / ____ DAD'S BIRTHDATE: ____ / ____ / ____

**PLEASE GIVE RECEPTIONIST INSURANCE CARDS TO COPY IF YOU HAVE NOT ALREADY DONE SO **
ALL PATIENTS MUST SIGN THE FOLLOWING ASSIGNMENT OF BENEFITS RELEASE**

I hereby assign all medical/surgical benefits, to include major medical benefits to which I am entitled, including Medicare, commercial insurance and other health plan, to William Kohen, M.D., Brenda Sanford, M.D., and/or Richard S. Bartholomew, D.O. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as original. I understand that I am financially responsible for all charges whether paid or unpaid by my insurance company or companies. I hereby authorize said assignee/Doctor to release all information necessary to secure payment of services rendered.

SIGNATURE: _____ DATE: _____ SOCIAL SECURITY #: _____

PRINT NAME: _____

FOR MEDICARE PATIENTS ONLY* MEDICARE ASSIGNMENT

I (patient name) _____ MEDICARE #: _____ request that payment or authorized Medicare benefits be made on behalf to doctors William Kohen, M.D., Brenda L. Sanford, M.D., and/or Richard S. Bartholomew, D.O. for any service furnished by them. I authorize any holder of medical information about me to be released to the health care financing administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I further understand this is one time authorization and can only be revoked by me in writing.*

SIGNATURE: _____ DATE: _____

PAYMENT IS EXPECTED AT TIME OF SERVICE FOR SERVICES NOT COVERED BY INSURANCE