CENTER FOR ADVANCED SPORTS MEDICINE

Millburn **Newark**

Date ___________

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT CLEARLY

Patient's Name: ______________________________________ DOB: __________ Age: ______ Social Security No.: ____________

Address: ____ City: ______________ State: ________ Zip: __________

Phone#: Home: _________________ Work: ________________ Cell Phone: ____________ E-mail Address: ___________________

Place of Birth: ___________________ Sex: M ____ F ____ Marital Status: M S W D Driver's License No: _______________

Occupation: ____________________ Patients Employer: ____
(Name) (Address)

Primary/Family Physician: ____
(Name) (Address) (Tel#)

Emergency Contact: ____ Phone: _________________
(Name) (Relation)

If Patient under 18 please complete:

Mother's ____
(Name) SS#

Father's ____
(Name): SS#

AUTOMBILE OR WORKER'S COMPENSTION INSURANCE INFORAMTION

Please note: The patient is liable for the bill, unless we receive written authorization from your worker's compensation carrier to treat you. Do you have approval? __________________

Date of Accident: ______________ Automobile Insurance Co/ W. Comp Insurance Company: ____________________

Address: ____ Tel#: __________________________________

Name of Adjuster: ____ Claim #:________________________

Nurse Case Manager: ____ Tel#: ____________________________

Attorney: ____ Tel#: ____________________________

Address: ____

I Authorize Payment of Medical Benefits to: **Center for Advanced Sports Medicine, Knee and Shoulder, 90 Millburn Ave Suite 204A Millburn, NJ 07041**

I Authorize Center for Advanced Sports Medicine, Knee and Shoulder (TCASM) to submit claims to my primary insurance carrier on my behalf. I also authorize assignment of benefits directly to the office, and release of my medical records requested by my insurance carrier (s). I also acknowledge that if TCASM does not receive payment from my insurance carrier, I will be held responsible for the balance of my bill. I have read all the information on this form and have completed this form. I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status of the above information. I acknowledge that I must pay any applicable copay at the time of my visit and failure to do so will result in rescheduling of my appointment. I acknowledge that there will be a $25.00 charge for failing to cancel a scheduled appointment.

____

(Signature of patient or party responsible for patient) **(Date)**

Workman's Comp: I have been given, read, and understand all of the information provided in the **WC Guidelines** ________ (initials)