Center for Advanced Sports Medicine, Knee and Shoulder
Millburn, NJ 07041

Today's 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 _____ **Father's** _____
(Name) SS# (Name): SS#

INSURANCE INFORMATION

Primary Ins.:_____ Name of Insured: _____ Relationship to Patient: _____

Employer: _____
Address

ID#: _____ Group # _____ D.O.B _____ SS# _____

Secondary Ins.: _____ Name of Insured: _____ Relationship to patient _____

Employer: _____
Address

ID#: _____ Group # _____ D.O.B: _____ SS# _____

I Authorize Payment of Medical Benefits to: Center for Advanced Sports Medicine, Knee and Shoulder
89 Millburn Avenue, Suite 102, Millburn, NJ 07041

I Authorize Center for Advanced Sports Medicine, Knee and Shoulder (CASM) to submit claims to my primary insurance carrier on my behalf. I also authorize the assignment of benefits directly to the office, and release of my medical records requested by my insurance carrier (s). I also acknowledge that if CASM 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 fee at the time of my visit.

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