THE CENTER FOR ADVANCED SPORTS MEDICINE

Millburn **Harrison**

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#

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: **The Center for Advanced Sports Medicine, Knee and Shoulder, P.O. Box 247, Summit, NJ 07901**

I Authorize The 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)