

**THE 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#

**AUTOMOBILE 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,  
90 Millburn Ave, Millburn, NJ 07041**

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)