**The Center for Advanced Sports Medicine, Knee and Shoulder**
**Millburn** **Newark**

**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# _____ Copay Amount: _____

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

Employer: _____
Address

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

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 a the time of my visit. 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)**