



# Hudson Valley Bone & Joint Surgeons, LLP



Date: \_\_\_\_\_

Acct#: \_\_\_\_\_

PATIENT NAME (Last, First) \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

CITY \_\_\_\_\_ STATE / ZIP \_\_\_\_\_

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
HOME PHONE NUMBER

SOCIAL SECURITY NUMBER \_\_\_\_\_

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
CELL PHONE NUMBER

EMPLOYER \_\_\_\_\_

(\_\_\_\_)\_\_\_\_-\_\_\_\_ EXT. \_\_\_\_  
WORK PHONE NUMBER

OCCUPATION \_\_\_\_\_

EMAIL \_\_\_\_\_

EMERGENCY CONTACT / PHONE NUMBER \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed Other

PHARMACY: \_\_\_\_\_

### PRIMARY PHYSICIAN:

PHYSICIAN'S NAME \_\_\_\_\_

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
OFFICE PHONE NUMBER

IS THIS INJURY RELATED TO: WORK \_\_\_ Y\_\_\_ N AUTO \_\_\_ Y\_\_\_ N SCHOOL \_\_\_ Y\_\_\_ N

PRIMARY INSURANCE CARRIER: \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_

POLICY / ID# \_\_\_\_\_

POLICY / ID# \_\_\_\_\_

GROUP# \_\_\_\_\_

GROUP# \_\_\_\_\_

### IF PATIENT IS A MINOR:

GUARANTOR \_\_\_\_\_  
GUARANTOR'S NAME

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
HOME PHONE NUMBER

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE / ZIP \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### MEDICARE PATIENTS:

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician services or organization to submit a claim to Medicare for payment to me.

### RESPONSIBILITY FOR PAYMENT:

I understand that I am responsible for any deductibles and co-insurance or services not covered by other insurance, unless prior arrangements have been made with the treating physician.

### ALL PATIENTS:

I understand that there is no guarantee that my insurance companies will pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all charges incurred.

I authorize the release of any information concerning my health and health care services to my insurance companies. I authorize payment of benefits to Hudson Valley Bone & Joint Surgeons for services rendered.

I am aware that Hudson Valley Bone & Joint Surgeon's Notice of Privacy Practices are available to me if I would like to have a copy.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE