

# GEORGETOWN ORTHOPEDICS, PLLC

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( ) New Patient ( ) Update  
( ) **Work Related Injury** – If yes – please report to front desk before visit.

## PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent Name if patient is less than 18 years of age \_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status S M D W (circle one)

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Relationship to patient: \_\_\_\_\_

## INSURANCE INFORMATION

**(Please present your insurance card/s to the front desk at time of check in)**

Primary Insurance Carrier: \_\_\_\_\_ Type of insurance (circle one) HMO PPO POS Other

Policy Number \_\_\_\_\_ Group Number or Name \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Policy Holder's Social Security Number \_\_\_\_\_

Relationship to Patient: Self / Spouse / Parent / Other (please explain) \_\_\_\_\_

We will file claims to your insurance carrier as a courtesy. It is the patient's responsibility to know if they are on a managed care policy and to contact their carrier to see if authorization or a referral is required to insure the highest level of payment. I hereby authorize this office to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance.

\_\_\_\_\_  
Patient's Signature (Guardian)

\_\_\_\_\_  
Date

**Medicare Authorization:** I authorize any holder of medical of other information about me to release to the Social Security Administration and Health Care Financing Administration of the intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assuagement. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any Medical costs not covered by Medicare.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date