Date: _____ **Welcome to Hudson Valley Bone &Joint Surgeons**

_____ Age: _____ ○ Male ○ Female
PATIENT NAME (Last, First)

_____ _____ DATE OF BIRTH: _____ /_____ /_____
ADDRESS APT. #

_____ (_____) _____- _____
CITY STATE/ZIP HOME PHONE NUMBER

_____ - _____ - _____ (_____) _____- _____
SOCIAL SECURITY NUMBER CELL PHONE NUMBER

_____ (_____) _____- _____ EXT: _____
EMPLOYER WORK PHONE NUMBER

_____ _____
EMPLOYER ADDRESS EMAIL

_____
EMERGENCY CONTACT / NUMBER

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

REFERRED BY: _____

PHARMACY _____
_____
_____
_____

IS THIS INJURY RELATED TO:
WORK ☐ Y ☐ N
AUTO ☐ Y ☐ N
SCHOOL ☐ Y ☐ N
OTHER ☐ Y ☐ N

PRIMARY PHYSICIAN:

_____ (_____) _____- _____
PHYSICIAN'S NAME (Last, First) OFFICE PHONE NUMBER

_____
ADDRESS CITY STATE / ZIP

PRIVATE INSURANCE:

PRIMARY INSURANCE CARRIER: _____

POLICY / ID#: _____ GROUP#: _____

CLAIMS MAILING ADDRESS: _____
ADDRESS CITY STATE / ZIP

INSURED'S NAME: _____ INSURED'S SS# _____- _____- _____

INSURED'S DOB: _____ / _____ / _____ RELATION TO INSURED: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER

SECONDARY INSURANCE CARRIER: _____

POLICY / ID#: _____ GROUP#: _____

CLAIMS MAILING ADDRESS: _____
ADDRESS CITY STATE / ZIP

INSURED'S NAME: _____ INSURED'S SS# _____- _____- _____

INSURED'S DOB: _____ / _____ / _____ RELATION TO INSURED: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER

IF PATIENT IS A MINOR:

GUARANTOR: _____ (_____) _____ - _____
GUARANTOR'S NAME HOME PHONE NUMBER

_____ SS# _____- _____ - _____
ADDRESS CITY STATE / ZIP

*** PLEASE SEE PAGE 2 / REVERSE SIDE ***

Patient Name:

WORKER'S COMPENSATION:

_____ DATE OF INJURY: _____ / _____ / _____
INSURANCE CARRIER

_____ (_____) _____ - _____ EXT: _____
ADJUSTER PHONE NUMBER

(_____) _____ - _____
FAX PHONE NUMBER

CARRIER CASE#:_____ WCB CASE#: _____

_____
CLAIMS MAILING ADDRESS CITY STATE / ZIP

_____ Was Injury Reported? ☐ Yes ☐ No
PART OF BODY INJURED

EMPLOYER: _____ (_____) _____ - _____

_____
STREET ADDRESS CITY STATE / ZIP

NO-FAULT:

_____ DATE OF INJURY: _____ / _____ / _____
INSURANCE CARRIER

_____ (_____) _____ - _____ EXT: _____
ADJUSTER PHONE NUMBER

_____ (_____) _____ - _____
PART OF BODY INJURED FAX PHONE NUMBER

CLAIM#: _____ POLICY#: _____

_____
CLAIMS MAILING ADDRESS CITY STATE / ZIP

NAME OF INSURED: _____ (_____) _____ - _____
PHONE NUMBER

_____
INSURED'S ADDRESS CITY STATE / ZIP

FOR 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 intermediates 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.

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

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.

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

FOR ALL PATIENTS:

I understand that there is no guarantee that my insurance companies will pay for all of my charges. Not withstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all charges incurred.

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

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.

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

I hereby acknowledge that I have been presented with a copy of Hudson Valley Bone & Joint Surgeon's Notice of Privacy Practices.

_____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE