



Welcome To Our Office

DATE _____

738 Newman Road
New Bern, NC 28560

Phone: (252) 634-2676
Fax: (252) 633-3502
www.carolinaorthopedics.com

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City/State: _____ Zip _____

Home Phone: () _____ Cell Phone: () _____ Marital Status: _____

Age: _____ SSN: _____ Birthdate: ____/____/____ Sex: M F Race _____

Primary Care Doctor: _____ Referred By: _____

Email : _____

Employer: _____ Work Phone: () _____ Ext. _____

Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: () _____

Cell Phone: _____

Student: Full Time Part Time Permanent Address: _____

Spouse/Guarantor Information:

Spouse/Guarantor Name: _____ DOB: ____/____/____ SSN: _____

Employer: _____ Phone () _____ Ext. _____

Occupation: _____

Other Parent Name: _____ DOB ____/____/____ SSN: _____

Employer: _____ Phone () _____ Ext. _____

Occupation: _____

Insurance Information:

Is it work related? _____ Date of Injury/Accident: ____/____/____ Auto Accident? _____

Insurance Information/Auto/Workers Comp. _____ Claim # _____

Have you consulted an attorney regarding your condition and/or accident? _____

If so, attorney Name and Address: _____

Primary Insurance Carrier:**Secondary Insurance Carrier:**

Insurance Company: _____

Insurance Company: _____

Policy No. _____ Group No. _____

Policy No. _____ Group No. _____

Insured's Name: _____

Insured's Name: _____

DOB: ____/____/____ Insured's SSN: _____

DOB: ____/____/____ Insured's SSN: _____

AUTHORIZATIONS and ASSIGNMENT:

I authorize the release of any medical information necessary to process the insurance claim form for services rendered by Carolina Orthopedics & Sports Medicine, Inc. I hereby authorize payment to go directly to Carolina Orthopedics & Sports Medicine, Inc. for any medical or surgical benefits that they may be entitled to under my medical and surgical plans. I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy.

Witness: _____ Signature: _____

Date: ____/____/____

MEDICARE ASSIGNMENT:

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 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 to the party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.) Regulations pertaining to Medicare assignment of benefits also apply.

Witness: _____ Signature: _____

Date: ____/____/____

AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION:

I authorize Carolina Orthopedics & Sports Medicine, Inc. to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Carolina Orthopedics & Sports Medicine, Inc.'s determination, are required to receive such information for the purpose of *medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Carolina Orthopedics & Sports Medicine, Inc.* I further authorize any other physician and/or medical facility to release my medical information to Carolina Orthopedic & Sports Medicine, Inc. for the purpose of my medical treatment and if applicable to process the insurance claim for services rendered at Carolina Orthopedics & Sports Medicine, Inc. This authorization shall remain in effect until written notice revoking this authorization is sent to Carolina Orthopedics & Sports Medicine, Inc.

Witness: _____ Signature: _____

Date: ____/____/____