Rockland Orthopedics & Sports Medicine, P.C.

MEDICARE

PATIENT INFORMATION SHEET

Patient Name _____ Gender: Male _____ Female_____
First Middle Last

Date of Birth _____/_____/_____ Social Security #_____-____-_____ Driver's Lic.# _____

Home Address _____

City _____ State _____ Zip _____

Billing Address (if different) _____

Home Phone (_____) _____ -_____ Cell Phone (_____) _____ -_____

Email Address _____

Marital Status S ___ M ___ D ___W___ Occupation _____

Primary Care Physician (PCP) _____ PCP Phone (_____) _____ -_____

Guardian's Name (if a minor) _____ Relationship to Patient _____

Patient's Employer _____ Work Phone (_____) _____ -_____

Employer's Address _____

Spouse's Name _____Spouse's SSN#_____-____-_____Spouse's DOB_____/_____/_____

Spouse's Employer _____ Spouse's Work Phone (_____) _____ -_____

Spouse's Employer's Address _____

If full-time student indicate school currently attendIng _____

Emergency Contact _____ Phone (_____) _____ -_____

PRIMARY INSURANCE CARRIER _____

Policy # _____ Group # _____ Phone (_____) _____ -_____

Address _____

Guarantor's Name _____ Relationship to Patient _____

Guarantor's SS# _____ - _____ - _____ Guarantor's Date of Birth _____/_____/_____

Employer _____ Employer's Phone (_____) _____ -_____

SECONDARY INSURANCE CARRIER _____

Policy # _____ Group # _____ Phone (_____) _____ -_____

Address _____

Guarantor's Name _____ Relationship to Patient _____

Guarantor's SS# _____ - _____ - _____ Guarantor's Date of Birth _____/_____/_____

Employer _____ Employer's Phone (_____) _____ -_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Rockland Orthopedics & Sports Medicine for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNED: _____ **DATE:** _____

PROVIDER'S SIGNATURE: _____ **DATE:** _____