ORTHOPAEDIC ASSOCIATES of Southern Delaware, P.A.

Patient Information

Patient Name **Social Security Number**	**Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____ **E-Mail Address (please print):**
Address **City, State & Zip Code** **FOR MEDICARE PATIENTS ONLY** Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Patient Sex** _____ **Date of Birth** _____ **Age** _____ ☐ **Married** ☐ **Single** ☐ **Other** **Spouse/Partner Name:**
Employment / Student Status: ☐ Full time employed ☐ Full time student ☐ Part time employed ☐ Part time student ☐ Unemployed ☐ Retired	**Employer Name & Address** _____ _____ **Occupation:**
Referring Physician Name	**Family Physician Name**
Patient Smoking Status ☐ Current everyday smoker ☐ Heavy tobacco smoker ☐ Current someday smoker ☐ Light tobacco smoker ☐ Former smoker ☐ Never smoker ☐ Unknown if ever smoker ☐ Smoker, current status unknown If you are a current smoker, what was your start date? _____ How many packs do you smoke a day? _____ If you are a former smoker, what was your quit date? _____ **Ethnicity of Patient** ☐ Hispanic Origin ☐ Unknown ☐ Non Hispanic Origin ☐ Declined to answer	**Race of Patient** ☐ American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White ☐ Unknown ☐ Declined to answer **Preferred Language of Patient** ☐ English ☐ Spanish ☐ Other _____
In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.	

Financially Responsible Person (if different from above)

Full Name _____ **Address** _____ **City, State & Zip Code** _____ **Date of Birth** _____ **Employer Name** _____	**Social Security Number #** _____ **Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____ **Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Primary Insurance Company Name		**Secondary Insurance Company Name**	
Address, City, State & Zip		**Address, City, State & Zip**	
Policy Holder	**Date of Birth**	**Policy Holder**	**Date of Birth**
Policy Holder Employer	**Policy Holder SSN**	**Policy Holder Employer**	**Policy Holder SSN**
Policy Number	**Group Number**	**Policy Number**	**Group Number**
Relationship to the Patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		**Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

MEDICATION HISTORY

I agree that Orthopaedic Associates of Southern Delaware, P.A., may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature of Patient or Guardian _____ Date _____

Preferred Pharmacy:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Mail Order:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS AND ACCOUNTS

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Orthopaedic Associates of Southern Delaware, P.A., for all services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay. Past due accounts will be placed with a collections agency. I understand I will be responsible for all costs of collection which may include collection fees, attorney fees and any other fees charged by the collection agency but not limited to a fee for partial payment made on the past due account.

Signature of Patient or Guardian _____ Date _____

MEDICARE PATIENTS

If you are covered by Medicare, please read and sign the following: In Medicare cases, Orthopaedic Associates of Southern Delaware, P.A., agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature of Patient or Guardian _____ Date _____

MISSED APPOINTMENTS

I understand that if I miss an appointment or cancel an appointment less than 24 hours before the appointment time, I will be responsible for paying a **$35.00 fee**. If there is inclement weather or other extenuating circumstances, exceptions may be made.

I understand that Orthopaedic Associates of Southern Delaware, P.A., is not able to bill my insurance company for missed appointments and that I will be responsible for the **$35.00 charge**.

Signature of Patient or Guardian _____ Date _____