SUPERIOR ORTHOPEDICS

Dr Joseph P. Spott

NEW PATIENT DEMOGRAPHICS

NAME_____ MALE/ FEMALE (circle one) BIRTHDAY_____

PATIENT SSN _____ PHARMACY _____

ADDRESS _____
(street address) (city, state, zip)

HOME PHONE # _____ CELL PHONE # _____

WORK PHONE # _____ PREFERRED # HOME/ CELL/ WORK (Please circle)

EMAIL _____ (for patient communication and appointment reminders only)

PRIMARY DOCTOR _____ CAREGIVER NAME _____

Tell us how you heard about Dr. Spott- _____

MARRITAL STATUS -- SINGLE/MARRIED/DIVORCED/WIDOWED

RACE -- AMERICAN INDIAN/ALASKAN NATIVE/ASIAN/ AFRICAN AMERICAN/PACIFIC ISLANDER/ WHITE/ UNKNOWN

ETHNICITY -- HISPANIC LATINO/ NON-HISPANIC LATINO/ UNKNOWN/ DECLINED

PATIENT EMPLOYER _____

EMPLOYER ADDRESS_____

IS THIS VISIT DUE TO A WORK-RELATED INJURY? YES/ NO

IS THIS VISIT DUE TO A MOTOR VEHICLE ACCIDENT OR THIRD PARTY INJURY? YES/ NO

If you answered YES to any of the above questions, please answer questions below

What was the date of the accident? _____

Where did the accident happen? _____

Was the accident reported? _____

Case manager name and phone number _____

INSURANCE INFORMATION

Please give insurance cards and identification cards (drivers license, state ID) to the front desk when signing in.

WHOSE NAME IS THE PRIMARY INSURANCE UNDER? _____

If different than yourself, please write: Date of Birth_____ **& SSN** _____

Relationship to you: (example: wife, husband) _____

SIGNATURE PAGE

Assignment of Insurance Benefits

I, the undersigned, certify that I (or my dependent) have the insurance coverage with the above company(ies) and assign directly to Joseph P. Spott D.O. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also give consent to have my prescriptions sent out electronically through the pharmacy provided.

_____ _____

Signature of Responsible Party **Date**

***I have read and understand the Privacy Act.**

_____ _____

Signature of Responsible Party **Date**

***I give my consent for Superior Orthopedics to retrieve my medication history.**

_____ _____

Signature of Responsible Party **Date**

Thank you!