# SUPERIOR ORTHOPEDICS

***Dr Joseph P. Spott***

## *NEW PATIENT DEMOGRAPHICS*

**NAME**_____ MALE/ FEMALE / _____

**BIRTHDAY**_____/_____/_____ **PATIENT SSN** _____

**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)

***HELP US SAVE PAPER! May we send paperless statements via email/text?**

**YES,** please send me paperless statements via email / **NO**, I prefer paper statements through mail.

**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

PHARMACY: NAME, ADDRESS, PHONE #

_____

## *PRIMARY INSURANCE INFORMATION*

**WHOSE NAME IS THE PRIMARY INSURANCE UNDER?** _____

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

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

**Insurance Name & ID #** _____

## *SECONDARY INSURANCE INFORMATION*

**Insurance Name & ID #** _____

-Please note that if you do not provide us with the proper insurance information, you may be billed the full amount for services-

## *COMMUNICATION PREFERENCES*

Who may we speak to about your medical care? NAME: _____PHONE#_____POA: YES/ NO

May we leave detailed voicemails on your preferred phone line? YES/ NO May we communicate via secured Email? YES/ NO

***IF THIS IS AN INJURY DUE TO A CAR ACCIDENT OR WORK RELATED INJURY PLEASE FLIP OVER AND FILL OUT THE BACK OF THIS FORM IN ITS ENTIRETY, if not, you may stop here and move to signature page**

**WAS THIS AN INJURY DUE TO AN AUTO ACCIDENT OR SOMETHING THAT HAPPENED AT WORK?**

What was the date of the accident? _____/_____/_____

Where did the accident happen?/ Details of the accident?

_____

_____

_____

Was the accident reported? _____

Name of insurance covering your case_____

If WORKERS COMPENSATION:

Case manager name and phone number _____

Adjuster name and phone number _____ FAX #_____

# 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' staff to send my protected health information via email under an encrypted and protected email source to which I am allowed to request and view any of these communications.**

_____ _____

**Signature of Responsible Party** **Date**

☐ Deny consent

**Thank you!**