

Orthopaedic Associates of Saratoga

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www.orthosaratoga.com

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____ DOB: _____ Age: _____

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Work Telephone: _____ E-mail: _____

Social Security #: _____ Drivers License #: _____

Name / Address of Referring Physician: _____

Parent Name if Minor: _____ Date of Birth: _____

Address (if different from above): _____

Social Security #: _____

Patient / Parent Employer Name / Address: _____

Emergency Contact: Name: _____ Phone #: _____

Is this injury related to work? Yes: _____ No: _____ (please notify receptionist if yes)

Is this injury related to a motor vehicle accident? Yes: _____ No: _____

Date of Accident or Injury _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Co-Pay: _____

Identification #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder Social Security #: _____

Policy Holder's Date of Birth: _____

Policy Holder's Employer Name / Address: _____

Patient Relationship to Policy Holder: Self _____ Husband _____ Wife _____ Child _____ Other _____

Secondary Insurance Carrier: _____

Identification #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Social Security #: _____

Policy Holder's Date of Birth: _____

Policy Holder's Employer Name / Address: _____

Patient Relationship to Policy Holder: Self _____ Husband _____ Wife _____ Child _____ Other _____

NO FAULT INFORMATION (MOTOR VEHICLE ACCIDENT)

Name / Address of Insurance Company of the vehicle you were in when accident occurred: _____

Telephone Number of Insurance Company: _____ Date of Accident: _____

Name of Policy Holder: _____ Policy #: _____

Claim #: _____

Consent To Treat

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my medical condition.

Patient's Signature _____ Date _____