Date _____ Next Gen # _____

FIRST STATE ORTHOPAEDICS

□ Dr. Jeremie Axe	□ Dr. Michael Axe	□ Dr. Bodenstab	□ Dr. Brady	□ Dr. Crain	□ Dr. Falvello	□ Dr. Ginsberg
□ Dr. Gotha	□ Dr. Handling	□ Dr. Johnson	□ Dr. Kahlon	□ Dr. Leitman	□ Dr. Lingenfelter	□ Dr. Manifold
□ Dr. Mavrakakis	□ Dr. Moran	□ Dr. Scott Newcomb	□ Dr.Newell	□ Dr. Pan	□ Dr. Pushkarewicz	□ Dr. Raisis
□ Dr. Rudin	□ Dr. Smucker	□ Dr. Sowa	□ Dr. Straight	□ Dr. Tooze	□ Dr. Zaslavsky	

PATIENT INFORMATION

Name _____ (LAST) (FIRST) (MI)
Address _____
Development _____
City/State/Zip _____
Home phone ( ) _____ Cell ( ) _____
Family Doctor _____ Phone ( ) _____
Referring Dr. _____ Phone ( ) _____
How did you hear about us? _____
Referring Attorney Name _____

Date of birth _____ □ Male
Age _____ □ Female
□ Single □ Married □ Divorced □ Widowed
□ Civil Union
E-Mail: _____
Occupation _____
Employer _____
Work Phone ( ) _____

OPTIONAL INFORMATION

Preferred Language _____ Race _____ Ethnicity _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT)

Name _____ (LAST) (FIRST) (MI)
Address _____
Development _____
City/State/Zip _____
Home phone ( ) _____

Relationship to Patient _____
Occupation _____
Employed by _____
Business Phone ( ) _____

INSURANCE INFORMATION

PRIMARY

Subscriber's Name _____ (LAST) (FIRST) (MI)
Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____

Patient's I.D. No. _____
Group/Account No. _____
Relationship to Patient _____
Date of birth _____
SS# TriCare or V.A. _____
Patient's Only

SECONDARY

Subscriber's Name _____ (LAST) (FIRST) (MI)
Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____

Patient's I.D. No. _____
Group/Account No. _____
Relationship to Patient _____
Date of birth _____
SS# TriCare or V.A. _____
Patient's Only

(✓ Box) **□ Auto Accident** **□ Work Injury** **□ Personal Injury**

Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____
Insurance Co. Phone ( ) _____
Name of Adjuster _____
Name of Attorney _____ Phone ( ) _____

Date of Injury _____
State in which injury occurred: _____
Claim Number _____
(Complete the following if accidental injury)
Where Accident Occurred: _____
How Accident Occurred: _____

FIRST STATE ORTHOPAEDICS

WHO MAY WE TALK TO ABOUT YOUR CARE?

You may communicate with the following individuals about my care:

Name	Relationship	Phone Number

FIRST STATE SURGERY CENTER / SPINE CARE DELAWARE/FIRST STATE IMAGING CENTER

The First State Surgery Center and Spine Care Delaware and First State Imaging Center are owned and operated by Physicians of First State Orthopaedics. While our outpatient surgery centers are an appropriate site for your surgical procedure, there are other facilities in the area where such procedures could also be performed. There will be a separate facility fee for surgeries performed at First State Surgery Center or Spine Care Delaware as there would be from any other facility.

FIRST ASSISTANT AT SURGERY

First State Orthopaedics, P.A. employs board certified physician assistants who are trained to perform the duties of a first assistant at surgery and to assist in the office. Our billing to your insurance carrier may include a fee for the physician assistant.

FINANCIAL RESPONSIBILITY STATEMENT / INSURANCE ASSIGNMENT

Please refer to the financial policy. Separate attachment.

I AGREE TO THE ABOVE CONDITIONS

If the patient is a minor, the parent or legal guardian must sign

Signature of patient, parent or legal guardian _____ Date _____

MEDICARE SIGNATURE ON FILE

" I request that payment of authorized Medicare benefits be made on my behalf to First State Orthopaedics, P.A., for any services furnished me by that physician's). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS), which oversees the Medicare program, and its agents any information needed to determine these benefits payable for related services."

Signed: Medicare Beneficiary _____ Date _____

THE PATIENT / GUARANTOR IS RESPONSIBLE FOR ALL ACCOUNT BALANCES AFTER INSURANCE HAS PAID