Center For Arthritis & Osteoporosis
Patient Information

Name: _____

Date of Birth: _____ Social Security # _____

Gender: □ M □ F

Marital Status: □ Single □ Married

□ Divorced □ Widow

Address: _____

City: _____

State: _____Zip_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Employer: _____

Address: _____

City/State/Zip: _____

Best phone for leaving messages? Home Work Cell

Primary Care Physician:_____

Referring Physician:_____

Spouse's Name_____

Date of Birth: _____ Social Security # _____

Cell Phone: _____ Alternate #_____

Employer: (spouse)_____

Work Phone: _____

Emergency Contact Name:_____

Address: _____

City/State/Zip_____

Phone #:_____Relation to you_____

Do you have a medical power of attorney, living will or advance directive?

□ Yes □ No

If you have one of the above, please bring a copy with you for your file.

Pharmacy Name:_____

Pharmacy Phone #:_____

Primary Insurance

Insurance Name:_____

ID #_____ GRP #_____

Holder of Ins:_____

SS#_____ Date of Birth:_____

Relationship: Self Spouse Parent Child Other

Secondary Insurance

Insurance Name:_____

ID #_____ GRP #_____

Holder of Ins:_____

SS#_____ Date of Birth_____

Relationship: Self Spouse Parent Child Other

Authorization to Release Information

_____ I hereby authorize telephonic/electronic/pick-up
Initials release of medical information to the following person.

Name:_____Phone#_____
Relationship: _____

Name:_____Phone#_____
Relationship:_____

Name:_____Phone#_____
Relationship:_____

I agree the above information is true. I hereby give consent for treatment for myself, by the physician and/or staff of Center For Arthritis & Osteoporosis.

I understand that I am responsible for all unpaid account balances including but not limited to co-payments, deductibles, balances and co-insurance at the time of service.

I understand that I am directly & primarily responsible to the Center For Arthritis & Osteoporosis for the usual & customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 60 days) in their paying, it is my sole responsibility to pay my bill directly. If not paid within 30 days late fees and / or court fees will be added to the balance.

Our charge for completion of any forms will be $15.00 per page. Charge for medical records will be $1.00 per page after the first free copy. There is a $45.00 return check fee on all returned checks.

I authorize the release of any medical or other information necessary to process claims. I also request payment be made directly to Center For Arthritis & Osteoporosis

By signing this authorization, I authorize CAO to use and/or disclose any protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO).

I have received a copy of the CAO Notice of Privacy Practices and understand that my protected health information may be used by the practice as described in the Notice. I also understand my rights to access and control such protected health information.

_____ _____
Patient Signature Date Staff (Witness) Date