



PATIENT INFORMATION	Patient's Name: _____ Phone: Home (____) _____ Cell (____) _____
	Patient's Address: _____ street city state zip
	DOB: _____ Sex: _____ Email Address: _____
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
	Social Security: _____ Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time Student
	Primary Care Physician: _____ City: _____ Phone: (____) _____
	Referring Physician: _____ City: _____ Phone: (____) _____
	Current Employer: _____ Occupation: _____ Work Phone: (____) _____
Employer's Address: _____ street city state zip (____) _____	
	Father's Name if patient is a minor _____ Address (if different than patient) _____ Work Phone (____) _____
	Mother's Name if patient is a minor _____ Address (if different than patient) _____ Work Phone (____) _____

INSURANCE	Primary Insurance Name: _____ Group #: _____ ID #: _____
	Subscriber's Name: _____ DOB: _____ SSN: _____
	Subscriber's Employer: _____ Work Phone: (____) _____
	Employer's Address: _____ street city state zip
	Patient's relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
	Secondary Insurance Name: _____ Group #: _____ ID #: _____
	Subscriber's Name: _____ DOB: _____ SSN: _____
	Subscriber's Employer: _____ Work Phone: (____) _____
Employer's Address: _____ street city state zip	
	Patient's relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____

ACCIDENT INFO	Were you injured in an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes? <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other: _____
	Name of Work/Auto/Liability Insurance: _____
	Insurance Address: _____ street city state zip
	Date of Accident: _____ Claim/Case# : _____
	Claim Adjuster: _____ Phone: (____) _____ Fax: (____) _____
	Attorney's Name: _____ Phone: (____) _____ Fax: (____) _____
	Attorney's Address: _____ street city state zip
	If Work, Employer at time: _____ Phone: (____) _____
Employer's Address: _____ street city state zip	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize payment of insurance benefits to be made directly to Connecticut Orthopaedic Specialists, P.C., and understand that I am financially responsible for payment to Connecticut Orthopaedic Specialists, P.C. for charges related to services provided to or incurred by me or my dependents, including items not covered by my insurance. I agree to pay a service charge to COS in the event I provide a check which is not honored by my bank and returned for "insufficient funds".

Signature _____ Date _____

ACKNOWLEDGEMENT OF HIPAA / NOTICE OF PATIENT PRIVACY AND HEALTH

I have received the notice of Use and Disclosure of Protected Information. I understand this notice and have had the opportunity to ask questions regarding any concerns. I hereby authorize the release of information to others as needed for COS to receive payment.

Signature _____ Date _____