Connecticut
ORTHOPAEDIC
& HAND SURGERY
CENTER
5 Founders St, Suite 202
Willimantic, CT 06226

REFERRING PHYSICIAN: _____

VERIFIED: _____ DATE: _____

PRIMARY PHYSICIAN: _____

VERIFIED: _____ DATE: _____

PATIENT INFORMATION (Please Print)				
NAME (Last Name, First Name, Middle Initial)	SOCIAL SECURITY #	DATE OF BIRTH		MALE ___ FEMALE ___
MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE
EMPLOYER/SCHOOL	OCCUPATION			WORK PHONE
EMPLOYER ADDRESS	CITY	STATE	ZIP	MARITAL STATUS SING. MARR. OTHER
IS CONDITION AUTO RELATED? YES ___ NO ___	IS CONDITION WORK RELATED? YES ___ NO ___	OTHER ACCIDENT (please explain)		
PARENT OR GUARDIAN'S NAME	NEXT OF KIN	PHONE NO.		

PRIMARY INSURANCE				
PRIMARY INSURANCE COMPANY NAME	MEMBER ID #			GROUP #
SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH		MALE ___ FEMALE ___
MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE
EMPLOYER	OCCUPATION			WORK PHONE

SECONDARY INSURANCE		
PRIMARY INSURANCE COMPANY NAME	MEMBER ID #	GROUP #
SUBSCRIBER'S NAME	EMPLOYER	DATE OF BIRTH

MEDICARE SIGNATURE	
NAME OF BENEFICIARY	ID NUMBER

I request that payment of authorized Medicare benefits be made either to me on my behalf or to Connecticut Orthopaedic & Hand Surgery Center for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE OF BENEFICIARY	DATE

ASSIGNMENT OF BENEFITS

I, _____ hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled to : Connecticut Orthopaedic & Hand Surgery Center. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

SIGNATURE	DATE	WITNESS