# ADVANCE Orthopedic & Sports Therapy, P.C.

**600 Clark Road, Tewksbury, MA 01876 978-452-3453 Fax: 978-452-2652**

## PATIENT INFORMATION

**NAME**_____ _____ _____ **M**_____ **F** _____
FIRST MI LAST SEX

**ADDRESS** _____**DOB** _____
# STREET CITY STATE ZIP

**SS#** _____ **HOME #** _____ **CELL #** _____

**EMPLOYER** _____
NAME CITY STATE PHONE #

**EMERGENCY CONTACT** _____
NAME PHONE # RELATION

**DIAGNOSIS** _____ **DATE OF INJURY** _____

**CAUSE OF INJURY: MVA** _____ **WORK** _____ **SLIP/FALL** _____**OTHER** _____

## POLICY HOLDER HEALTH INSURANCE INFORMATION

**SUBSCRIBER** _____
NAME PHONE #

**DOB** _____ **EMPLOYER** _____
NAME PHONE #

**PATIENT'S RELATION TO INSURED: SELF** _____ **SPOUSE** _____ **CHILD** _____

**INSURANCE** _____
NAME PHONE #

**ID #** _____ **GROUP #** _____

**PRIMARY CARE PHYSICIAN** _____
NAME PHONE #

**REFERRING MD** _____ **SCRIPT DATE** _____
NAME

***AUTO INSURANCE INFORMATION*** _____ ***WORKER'S COMPENSATION INSURANCE*** _____

**INSURANCE** _____
NAME PHONE #

**CLAIM #** _____ **POLICY HOLDER** _____

**ADJUSTER** _____ **PHONE #** _____ **EXT** _____

## FOR OFFICE USE ONLY

**ACCOUNT #** _____ **CO-PAY** _____ **1ST DATE OF SERVICE** _____

**AUTHORIZATION #** _____ **DATES COVERED** _____

**DIAGNOSIS** _____ **ICD 9** _____ **UPIN #** _____

**DIAGNOSIS** _____ **ICD 9** _____ **PCC #** _____

**DIAGNOSIS** _____ **ICD 9** _____

**Inconsideration of the services rendered and to be rendered, I authorize the release of medical or other information necessary to process this claim. I authorize payment of medical benefits to AOST. I understand that I am fully responsible for any deductibles, co-pays and/or unpaid charges that my insurance does not cover.**

**Signature of Patient** _____ **Date** _____