5134

beach cities orthopedics & sports medicine

PATIENT INFORMATION (MINOR)

Patient's Name: AHN MD, ANTHONY DOB: 09-24-1972 Date: 03-23-2016

Address: _____ Age: 43 Y/O Gender: M

City: _____ State: _____ Zip: _____ Home Phone: (917)826-9559

SSN: _____ Driver's Lic: _____ Cell Phone: _____

Email: _____

Parent/ Guardian Name: _____ Parent/ Guardian SSN: _____

Parent/Guardian Employer: _____ Business Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Name of Pediatrician: _____

Name of Referring Physician/Therapist/Trainer: _____

Additional Emergency Contact: _____ Relationship: _____ Phone: _____

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Was the injury a result of an accident? (circle one) Yes No

Was an autombile involved? (circle one) Yes No

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INSURANCE INFORMATION

Person responsible for the payment?

□ **Parent** □ **Cash** □ **Auto** □ **Legal**

In addition to your insurance card this information must be fully completed in order for us to courtesy bill your insurance company.

PRIMARY Insurance Co: _____ Name of Policy Holder: _____

Insured Employer: _____ Insured DOB: _____ Relationship to self: _____

Insured SSN: _____ ID#: _____ Group#: _____

SECONDARY Insurance Co: _____ Name of Policy Holder: _____

Insured Employer: _____ Insured DOB: _____ Relationship to self: _____

Insured SSN: _____ ID#: _____ Group#: _____

If you checked "legal" above, please provide your attorney's name: _____

Address: _____ Phone: _____

**********AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**********

If your check is returned by the bank, a $20 service charge will be added to your account. I request that payment of authorized Medicare/ Other insurance company benefits be made to Beach Cities Orthopedics and Sports Medicine for any services to me by the physician who accepts assignment. Regulations pertaining to Medicare apply. I authorize any holder of medical, or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information needed for this or related Medicare/ Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original. I understand that it is mandatory to notify the healthcare provider or any other party who may be responsible for paying for my treatment. (Section1128B of the social Security Act and 31U.S.C. 381-3812 provides penalties for witholding this information). Conditional payment of any charges resulting from 3rd party liability will be requested from the insurance company. At the time of settlement of 3rd party liability cases, insured will be responsible for reimbursing the insurance company payments made and the payment in full for any medical charges incurred in this office relating to said inquiry. I understand that payment is my obligation and responsibility, regardless of insurance and other third party involvement. I have read and understand possible financial responsibility for services rendered and hearby affix signature as acknowledgement of this understanding.

03-23-2016

Signature of Parent/ Guardian

Date