

**Patient Information**

ARTHRITIS & OSTEOPOROSIS CENTER, P.C.

TODAY'S DATE	REVISED DATE
REFERRED BY	

WELCOME TO OUR OFFICE: In order to serve you properly, we need the following information. All information is strictly confidential.

PATIENT'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH (MO DA YR)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W
HOME ADDRESS STREET	CITY	STATE	ZIP CODE	HOME PHONE	
PATIENT'S SOCIAL SECURITY NUMBER			PARENT'S NAME (IF PATIENT IS UNDER 18 YEARS OLD)		
PATIENT'S (OR PARENT'S) EMPLOYER				BUSINESS PHONE NUMBER	
EMPLOYER'S ADDRESS			OCCUPATION		
ANY ADDITIONAL PHONE NUMBERS					
SPOUSE'S NAME				SPOUSE'S BUSINESS PHONE NUMBER	

**INSURANCE INFORMATION**

<b>FOR MEDICARE PATIENTS</b>	DO YOU HAVE MEDICARE PART B? (Payment of Doctors' Charges) <input type="checkbox"/> YES <input type="checkbox"/> NO				
	IF YOUR MEDICARE IS PRIMARY, WHAT INSURANCE IS SECONDARY? <input type="checkbox"/> NONE				
	IF YOUR MEDICARE IS SECONDARY, WHAT INSURANCE IS PRIMARY?				
<b>FOR NON-MEDICARE PATIENTS</b>	NAME OF INSURED		INSURED'S SOCIAL SECURITY NUMBER		RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE
	INSURED'S DATE OF BIRTH	INSURED'S PLACE OF EMPLOYMENT			
	PRIMARY INSURANCE CARRIER			IDENTIFICATION NUMBER	
	SECONDARY INSURANCE CARRIER			IDENTIFICATION NUMBER	

**MEDICAL INFORMATION**

NAME OF PHYSICIAN WHO REFERRED YOU TO THIS OFFICE?		IF REFERRED BY OTHER THAN A DOCTOR, PLEASE SPECIFY
REASON FOR YOUR VISIT TODAY		
LIST ALL KNOWN ALLERGIES		
LIST ANY MEDICATIONS YOU ARE NOW TAKING		
NAME OF YOUR MEDICAL DOCTOR	NAME OF YOUR PHARMACY	PHARMACY PHONE NUMBER
NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY		PHONE NUMBER

**PAYMENT POLICY – MEDICAL AUTHORIZATION – ASSIGNMENT OF BENEFITS**

To our non-Medicare patients: We will be happy to file your insurance claims. At time of visit, you will be financially responsible for co-pays, deductibles, coinsurance and uncovered charges & services.

To our Medicare patients: We are participating in the Medicare program and accept assignment for all covered charges. You are financially responsible for any non-covered charges, your annual Medicare deductible and any part of the 20% co-payment not paid by a secondary insurance. I authorize this office to release any medical information necessary in order for my insurance company(s) to process my claim(s). I authorize that payment of medical benefits be sent to "Arthritis & Osteoporosis Center, P.C." or Deborah Desir, M.D." for services rendered. I have read, understand and agree to all of the above.

SIGNATURE OF PATIENT	DATE	SIGNATURE OF SUBSCRIBER	DATE
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