PATIENT INFORMATION

Sterling Doster, M.D. Gregory Fox, M.D. Erich Weidenbener, M.D.

Dale Dellacqua, M.D. Alex Meyers, M.D. Michael Pannunzio, M.D.

TODAY'S Date	:	Name (Last, First, Mi	ddle):					
Address:		` ` ' '	City	:		ST:	ZIP:	
Home Phone ()	Work Phone ()		Mobile Phone:	()		
SSN:	-	- Age:		DOB:			Marital Status: M S D O	
Sex:	Employer:				Referring Doc	tor	Marital Status: M S D O	
Person to Contac	ct in case of emerg	gency:				Phone:	()	
Person to Contac	ct other than relati	ve:	Phone: ()					
Primary Plan Na	INSURANC	E POLICY INFORMAT	TION (Please Billing	present in g Address:	nsurance card at ti	ime of c	zip:Co-pay \$	
Card Holder's N	Inma (Last First)	Oroup #		A ddrag	CStreet City ST	Zin)	Co-pay \$	
Lagurad's Emplo	iailie (Last, Fiist, I	VII)	E.	Addres	s (Sileet, City, S1,	Zip)	ata of Dinth	
Caran dama Dian	N		Employer Insurance Plan: Yes / No Date of Birth					
Secondary Plan	Name:	C #	Address (Street, City, ST, Zip) Group # Ins ID # Co-pay \$ Employer Insurance Plan:Yes / No Date of Birth / /					
Pnone: ()		Group #	Of Oup # Ins ID # Co-pay \$					
insured s Emplo	oyer:		Emplo	yer insura	nce Plan: Yes / No	Date of	Birtin/	
Address: (Street Social Security #	#, City, ST, Zip)	/ Sex: M / F N	Marital Status:	M S D (Phone: () O Relationship to :	Patient:	Age:	
		ring into an agreement wi						
payment. Some	companies pay fi	considered a method of r ked allowances for certain surance or other balances	n procedures;	others pay	a percentage of the	charge	. It is your responsibility to	
assigned to collect may be added pre-	ion and/or suit, the	judgment interest at the curr	led to reasonabl	le attorney f	fees, cost of collection	ns and/or	RVICE. If this account is collection agency fees, to which unpaid amounts will be assessed	
record. I hereby Clinic, P.C. Thi as an original.	assign all medicals assignment will I understand that I	l and/or surgical benefits remain in effect until revo	under the tern oked by me in le for all charg	ns of my in writing.	nsurance payable to A photocopy of this	: Bloon s assigni	of portion(s) of the patient's nington Bone and Joint ment is to be considered valid ance. I hereby authorize said	
procedures perfo		provide the finest care our should be understood that response.						
		and Joint Clinic, P.C. to bloyer and/or any other he						
I authorize Bloomedical record.	mington Bone and	I Joint Clinic, P.C. or thei	r representativ	ve to take o	clinical photographs	s of me,	to be kept as part of my	
Signature:					Date:			
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