IF FORM IS NOT COMPLETELY FILLED OUT BILLS WILL BE SENT DIRET TO YOU

Date: ________________

LAST NAME: ________________________________ **FIRST:** ________________________________ **MIDDLE:** _____________
ADDRESS: _____________________________________ **CITY:** ____________________________________ **ZIP:** ______________
AGE: _______ **DATE OF BIRTH:** ___________________ **PHONE: (____)** ____________________ **SS#:** ___________________
EMPLOYMENT:
EMPLOYER & ADDRESS: ____ PHONE: _______________________
SPOUSE: NAME & ADDRESS: ____
SPOUSE: EMP. & ADDRESS: ____ PHONE: ______________________

FRIEND/RELATIVE NOT LIVING WITH YOU:
NAME: ____ RELATIONSHIP: ______________________________
ADDRESS: ____ PHONE: ______________________
HAVE YOU EVER BEEN TREATED BY OUR DOCTORS? YES _______ NO ________ DATE: __________________________
FAMILY PHYSICIAN: ____________________________ **ADDRESS:** ____

FOR CHILD:
Father's name & address: ____
Father's phone: __________________________________ SS#: ______________________________ Date of Birth: ______________
Father's employer: ____
Address: ____ Phone: ________________________
Mother's name & address: ____
Mother's phone: __________________________________ SS#: ______________________________ Date of Birth: ____________
Mother employer: ____
Address: ____ Phone: ________________________

INSURANCE INFORMATION:
Date of Injury: ______________________________ Compensation ___ Medicaid ___ Medicare ___ No Fault ___
Private Ins.: ____ ID#: ________________________________
Address: ____
Insured's Name: ______________________________ Date of Birth: ___________________ SS#: __________________________
Secondary Ins.: ____ ID#: ________________________________
Address: ____
Insured's Name: ________________________________ Date of Birth: ___________________ SS#: __________________________

ASSIGNMENT OF BENEFITS AND INFORMATION

ANY NON-COVERED CHARGE FROM THE INSURANCE COMPANY IS THE PATIENT'S RESPONSIBILITY

***** A collection fee will be added if placed for collection due to non-payment – it is the patient's responsibility. *****

I authorize release of information from my records, even if it should contain alcohol, drug, HIV, or AIDS information. I also understand that insurance forms are completed as a courtesy to me and that I am responsible for the unpaid balance or insurance non-payment. I hereby authorize payment directly to Genesee Orthopedic & Hand Surgery, P.C.: Dr. Kenneth Kim, Dr. Peter Freedman, Dr. James Dennison, Dr. Andrew Wickline, and Dr. Jonathan Wigderson.

____ Date: __________________________
Patient/authorized signature

MEDICARE SUPPLEMENTAL ASSIGNMENT

I authorize holder of medical information about me to release to (MEDIGAP insurer) any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized MEDIGAP benefits bmade to Genesee Orthopedic & Hand Surgery Assoc., P.C.: Dr. Kenneth Kim, Dr. Peter Freedman, Dr. James Dennison, Dr. Andrew Wickline, and Dr. Jonathan Wigderson.

____ Date: __________________________
Patient/authorized signature