ST. CLAIR ORTHOPAEDICS AND SPORTS MEDICINE, P.C.

23829 Little Mack, Suite 100
St. Clair Shores, MI 48080
Phone (586) 773-1300
Fax (586) 773-1600

Welcome to Our Practice

45441 Heydenreich
Macomb, MI 48044
Phone (586) 416-1300
Fax (586) 416-0800

PATIENT INFORMATION

Patient Name: ____
Last Name First Name Initial

Date of Birth: ______________________ Social Security Number: ______________________

Address: ____

City: ______________________________ State: ________ Zip: ______________

Employer: ______________________ Single: ____ Married: ____ Divorced: ____ Widowed: ________

Home Phone: ______________________ Alternate Phone: ______________________

EMail Address: ____

RACE/ETHNICITY

RACE			**ETHNICITY**
American Indian/Alaska Native	Asian	Black/African American	Hispanic/Latino
Nat Hawaiian/Pacific Islander	Other	Unknown	Not Hispanic/Latino
White/Caucasian			

PRIMARY CARE PHYSICIAN / REFERRING PHYSICIAN

PCP Name: ______________________ Referring Name: ______________________

Phone Number: ______________________ Phone Number: ______________________

PHARMACY INFORMATION

Name: ______________________ City: ______________________

Crossroads: ______________________ Phone Number: ______________________

WORKER'S COMPENSATION/AUTO INSURANCE

*Is this visit related to an Auto Injury or Worker's Compensation Injury? (Circle) Yes No Auto W/C

PRIMARY INSURANCE INFORMATION

Insurance Name: ______________________ Employer: ______________________

Policy Holder: ______________________ Date of Birth: ______________________

SECONDARY INSURANCE INFORMATION

Insurance Name: ______________________ Employer: ______________________

Policy Holder: ______________________ Date of Birth: ______________________

SHARING OF MEDICAL/ACCOUNT INFORMATION

Who May Pick Up Records or Discuss Care On Your Behalf? ______________________

Who May Speak On Your Behalf Concerning Your Billing Account? ______________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have made with the insurer).

Insurance companies DO NOT make us aware of all restrictions, such as pre-existing clauses, when we verify services. I am aware that if there is a pre-existing clause on my insurance plan, I may be responsible for anything that is not covered by my insurance company.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I HAVE RECEIVED NOTICE OF THIS ORGANIZATIONS PRIVACY PRACTICES.

Patient Signature: ______________________________ Date: ______________