

ORTHOPEDIC SURGERY INSTITUTE, INC.

Apple Hill Medical Center
25 Monument Road, Suite 290
York, PA 17403

Memorial Medical Center
1779 Fifth Avenue
York, PA 17403

OSI at Cross Keys
2900 Carlisle Pike
New Oxford, PA 17350

DEAN A. NACHTIGALL, D.O.

CRAIG A. SULLIVAN, D.O.

SETH D. BAUBLITZ, D.O.

LALEH S. RADFAR-BAUBLITZ, D.O.

PLEASE PRINT CLEARLY

TODAY'S DATE _____

Patient's Name _____ Age _____ Birthday _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Male Female Single Married Divorced Separated Widowed

Patient's Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Employer _____

Address _____ City _____ State _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship _____

Address (if different from above) _____

Home Phone _____ Work Phone _____ Social Security # _____

Employer _____ Occupation _____

Address of Employer _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

MEDICARE

Medicare I.D. # _____

PRIMARY _____ Address _____

I.D. # _____ Group # _____

Name of Policy Holder _____ Relationship _____

Policy Holder Date of Birth _____

SECONDARY _____ Address _____

I.D. # _____ Group # _____

Name of Policy Holder _____ Relationship _____

Policy Holder Date of Birth _____

How did you hear about our office? Doctor Emergency Room Friend Family Yellow Pages Insurance Co.
 IRC Concentra Employer WorkFirst

HISTORY OF INJURY/ILLNESS

Nature of Problem _____

Is Injury/Illness Related To: Work Auto Other School/Sports - Name of School _____

Date of Injury/Onset of Illness _____ Where Occurred _____

How Occurred _____

Were X-Rays Taken? Yes No Where? _____

Have You Been Treated for Above Problem? _____ Where? _____

Referring Doctor _____ Family Doctor _____

ADDITIONAL INFORMATION REQUIRED REGARDING:

WORKERS' COMPENSATION CLAIM

Employer _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Date of Accident _____ Did You Report This to Your Employer? Yes No
Has This Been Approved as a Workers' Compensation Case? Yes No Contact: _____
W.C. Ins. Co. _____ Claim # _____
Address: _____ Phone #: _____

(List Personal Insurance information on the FRONT under "Secondary Insurance.")

AUTOMOBILE ACCIDENT

YOUR Automobile Insurance Carrier _____
Address _____ City _____ State _____ Zip _____
Policy # _____ Claim # _____ Date of Accident _____
Claim Representative _____ Phone _____
Personal Medical Ins. _____ Address _____
I.D.# _____ Group # _____
Name of Policy Holder _____ Relationship _____

LIABILITY CLAIM

Responsible Party Name _____ Contact Person _____
Address _____ City _____ State _____ Zip _____
Personal Medical Ins. _____ Address _____
I.D.# _____ Group # _____
Name of Policy Holder _____ Relationship _____

IF YOU HAVE OBTAINED THE SERVICES OF AN ATTORNEY, PLEASE COMPLETE THE FOLLOWING

Attorney's Name _____
Address _____ Phone # _____

AUTHORIZATION TO PAY: In consideration for services rendered, I hereby authorize direct payment of medical benefits and/or surgical benefits, to include Major Medical benefits I am entitled to, plus Medicare, Blue Cross Blue Shield, private insurance, and any other health plan to ORTHOPEDIC SURGERY INSTITUTE, INC. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

AUTHORIZATION TO RELEASE RECORDS: I hereby authorize the release of any medical records or information deemed necessary to the Social Security Administration, Health Care Financing Administration, my insurance company or its intermediaries or carriers, to Orthopedic Surgery Institute or any other doctor's office, or to my attorney.

Signature of Patient or Guardian _____ Date _____