

Memorial Medical Center  
1779 Fifth Avenue  
York, PA 17403

**ORTHOPEDIC SURGERY INSTITUTE, INC.**

Hillside Medical Center  
250 Fame Avenue, Suite 205  
Hanover, PA 17331

DEAN A. NACHTIGALL, D.O.

CRAIG A. SULLIVAN, 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**

**PRIMARY** \_\_\_\_\_ Address \_\_\_\_\_

I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_ Policy Holder SS# \_\_\_\_\_

Policy Holder Employer (name, city, state) \_\_\_\_\_

**SECONDARY** \_\_\_\_\_ Address \_\_\_\_\_

I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_ Policy Holder SS# \_\_\_\_\_

Policy Holder Employer (name, city, state) \_\_\_\_\_

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.")*

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**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 \_\_\_\_\_

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**LIABILITY CLAIM**

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

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**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 \_\_\_\_\_