ORTHOPAEDIC SOLUTIONS AND SPORTS MEDICINE CENTER PA
JAY R. PARIKH MD, FRCSC, FACS

PATIENT INFORMATION **CHART #** _____

Patient _____ SSN_____DOB_____

Address _____

Home Phone _____Cell_____Sex____M___F___O

Email: _____

Marital Status ___Single __Married __Widowed ___Divorced ___ Occupation _____

Employer Name/phone # _____

Spouse's Name_____SSN_____DOB_____

IF MINOR:

Father's Name_____SSN_____DOB_____

Mother's Name_____SSN_____DOB_____

FAMILY Physician Name/Phone _____

REFERRING Physician/Phone _____

EMERGENCY Contact Name/Phone_____

CONSENT:

Insurance Authorization: I request that payment of authorized benefits to be made to the above-named provider on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any third-party payer, state medical assistance agency, or any other governmental or benefits for related services. I agree to pay for all charges not covered by a third-party payer. OSSM does not file Medicaid secondary unless Medicaid automatically crosses over with the primary insurance.

I certify that the above information is true and correct to the best of my knowledge. I give my permission for the rendering provider to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment.

I authorize and request payment from MED PAY settlement and/or final settlement be assigned directly to Orthopaedic and Sports Medicine Center for services rendered relative to the any liability accident and that I am responsible for any non-covered services and any balances that may remain due to pro-rata settlements to medical providers involved with this accident. **OSSM does not hold any unpaid accounts until law suits are settled.**

Patient Signature: _____Date:_____