THE ARTHRITIS CENTER OF CONNECTICUT

RHEUMATOLOGY DIVISION

PATIENT INFORMATION

Last Name________________________________First Name______________________________M.I.____________________

Street Address____City,State,Zip__________________________________

Date of Birth_________________Marital Status___________Sex_____Social Security Number#_________________________

Home Phone______________________Mobile Phone__________________Work Phone______________________________

Email Address____Can we send you communication by email?________________

Name and address of employer____

Spouse's Name____Spouse's Social Security #________________________

In case of emergency, please list the name, relationship, and phone number of nearest relative__________________________

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Please list any allergies to medications that you have ____

Primary Care Physician_____________________________Address______________________________Phone #___________

Referring Physician________________________________Address______________________________Phone #___________

HEALTH INSURANCE

PRIMARY INSURANCE____ID#_____________________________________

SECONDARY INSURANCE____________________________________ID#_____________________________________

IS THIS A WORK RELATED INJURY? Y OR N (CIRCLE ONE)

If yes, what is the date of injury_________________________________Part of body injured?_____________________

Name and address of compensation carrier____

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Name of contact person________________________________Phone #____

IS THIS A MOTOR VEHICLE ACCIDENT Y OR N (CIRCLE ONE)

If yes, what is the date injury?___________________________________Part of body injured?_____________________

Name and address if insurance company____

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PHYSICIAN NOTICE TO PATIENT ABOUT MEDICARE

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

Medicare Recipient's Signature______________________________Date_________________________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances on certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for you by your insurance.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF DIRECTLY TO THE ARTHRITIS CENTER OF CONNECTICUT, RHEUMATOLOGY DIVISION.I certify that the above information is true, I authorize the release of all medical records to my primary care physician, other treating physicians, and to my insurance company. If applicable, I understand that payment of charges incurred is use at the time of service, unless other definite arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

Signature____Date________________________________