SHORE SPORTS MEDICINE

JAMES R. MORALES, MD

Patient Information

Name: ______________________________ Date: ____________________

Address: ____

City: ______________________ State:__________ Zip: __________________

Telephone: Home ____________________Work ___________________________

Cell Phone: ______________________ E-Mail: ____________________________

DOB: ______________ Age __________Sex: ______________________

Social Security Number: ______________________________________

Martial Status: M / S / D / W Employment Status: ______________________

Primary Physician: ____

Address: ____________________________________ Phone: ______________

Who referred you to this office? ____________________________________

Primary Insurance

Insurance Company: ____

Address: ____

Policy Number: ____________________ Group Number: ____________________

Subscriber's Name: ____

Social Security Number: ______________________DOB: ____________________

Subscriber's Employer: ______________________Phone: ____________________

Primary Insurance

Insurance Company: ____

Address: ____

Policy Number: ____________________ Group Number: ____________________

Subscriber's Name: ____

Social Security Number: ______________________DOB: ____________________

Subscriber's Employer: ______________________Phone: ____________________

Is this injury related to:

Work: __________ Motor Vehicle: ________

If work or motor vehicle related –

Insurance Company: ____

Adjuster/Case Manager: ______________________________________

Address: ____

Phone #: ______________________ Fax #: ______________________

Claim #: _________________

Employer: ____

Address: ____

Phone #: ______________________ Fax #: ______________________

Attorney Name: ____

Address: ____

Phone #: __________________

Medicare Beneficiaries

I request that payment of authorized Medicare benefits be made on my behalf to Shore Sports Medicine for service furnished me by the physician. I authorize medical information concerning my care be released to the Centers for Medicare and Medicaid Services, or its authorized agents, as necessary to determine if medical services provided to me are payable.

________________________________ ________________

Patient Signature Date

I, the undersigned, authorize payment of medical benefits to Shore Sports Medicine for all services provided to my by the physician. I understand and agree that I am financially responsible for any amount not covered by my insurance contract. I authorize the release to my insurance company of information concerning my medical care and treatment, to include medical supplies or equipment provided to me. This information will be furnished for the purpose of evaluation and administering claims for benefits.

________________________________ ________________

Patient Signature Date