AO ORTHOPEDICS, INC.

Vincent R. Avallone Jr., D.O.
Donald D. Diverio Jr., D.O.
Paul M. Simonelli, D.O.
A.O.B.O.S. Board Certified Orthopedic Surgeons
Locations in: Lancaster Lebanon Ephrata with satellite office in Elizabethtown

Patient Information

Patient Name: ____

Sex ______ Age ________ DOB_____/_____/_____ SS#______-______-______

Responsible party (if patient under 18) ___________________________ Relationship _______________________

Address: ____

City: ___________________________, State: __________ Zip: _________

Home Ph#: (______)______-________ Cell Ph#:(______)______-________ Work Ph# (______)______-_______

Name of employer ____

Family Physician (*Doctors name not practice name*): ________________________________

How were you referred to our practice? ________________________________

Injury / Condition Information

What is the reason for the appointment? ____

When did the injury occur? ________________ **Did you have the following: Xrays____ MRI____ Other_________**

Was the injury **Work Related**? (**Yes / No**) Was the injury **Automobile related**? (**Yes / No**)

Name of Work Supervisor: ________________________________ **Telephone#** (______)______-___________

Name of Claims Adjuster:_________________________________ **Telephone#** (______)______-___________

Insurance Information

Primary Insurance: ______________________________ **Secondary Insurance:** ____________________________

Policy Holder Name _____________________________ **Policy Holder Name** _____________________________

Policy Holder DOB: _______/______/_______ **Policy Holder DOB:** _______/______/_______

ID / Claim Number: _____________________________ **ID / Claim Number:** _____________________________

Group Number: _____________________________ **Group Number:** _____________________________

Group / Employer Name: _________________________ **Group / Employer Name:** _________________________

Effective Date: ______/_____/______ Effective Date: ______/_____/______

Physician to be seen: Dr. Avallone / Dr. Diverio / Dr. Simonelli
Date Appt called in: ____/____/____ **Account#:** ___________________
Appointment Date: ____/____/____
Appointment Time: _______________ **Scheduled by :** ________________
Checked In by: _____________

Please complete back of form and any additional releases attached

Persons authorized to discuss my personal information

I authorize **AO Orthopedics, Inc.** to discuss my personal health Information by Telephone, Writing or in Person to the following people. I understand that if I do not list a person, the practice will not disclose any information to any individual requesting information.

1)______________________________________ **2)______________________________________**

3)______________________________________ **4)______________________________________**

4)______________________________________ **6)______________________________________**

Commercial Insurance HMO's & PPO's

I hereby authorize **AO Orthopedics, Inc.** to release any medical information in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to co-insurance, co-payment, deductible and non-covered services.

Signature: ____ Date: ______/______/______

(Parent and / or Guardian if Patient is a minor)

Medicare Patients:

Patient's Name: ________________________________

I request that payment of authorized Medicare benefits be made on my behalf to **AO Orthopedics, Inc.** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: ____ Date: ______/______/______

(Beneficiary Signature)

Medicare Supplemental / Medigap Insurance:

I request that payment of authorized MEDIGAP benefits be made on my behalf to **AO Orthopedics, Inc.** to release to my Medicare Supplemental and / or MEDIGAP carrier any information needed to determine these benefits payable for related services.

Signature: ____ Date: ______/______/______

(Beneficiary Signature)