PATIENT NO FAULT INFORMATION

NP NI FU INJ FX AC DOCTOR________ ACCT#__________

The Central Orthopedic Group, LLP [illegible]

DATE ________________

Patient Last name______________________**First**____________________DOB_________Age _____

Parent or Guardian (if under 18)____________________________ Contact Phone # ______________________________

Address _____________________________**City** _______________**State** _________**Zip Code** _________

Home Phone # ________________________ Work # ______________________ Cell #______________________

S.S. #__________ Male____ Female____ Employer____________________ **Email:**_________________________

Referring Physician _______________________________ Address ______________________________________

Telephone #____ Fax #____

Primary care physician (if different from referring physician) ____

Address ______________________________Telephone # ______________________ Fax #___________________

BODY PART____ **RIGHT / LEFT (*CIRCLE*)**

Date of Injury______________________________ **Duration of Problem** ____________________________________

Seen in Emergency room? YES OR NO (*CIRCLE*) Date___________________ **Name of Facility**________________

X-Rays Taken ? YES OR NO Date _________________ **Facility** _______________________________

MRI/ CT SCAN Taken? YES OR NO Date _________________ **Facility** ________________________________

Pharmacy Name _______________**Telephone #** _______________ **Address** _____________________________

NO FAULT INFORMATION

Name of Insurance Company _____________________ Address ____

Date of Accident ____________ Claim Representative ______________________ Telephone # ___________________

Did you report your accident to your carrier? Yes ____ No ____ Did you complete a NF2 form? Yes _____ No _____

Policy # _______________________ Policy Holder ______________________ File/Claim# ______________________

PRIVATE INSURANCE INFORMATION:

Name of Insurance Company ____ Policy #______________________

Name of Policy Holder _____________________________ Relationship to Patient _____________________________

DOB of Policy Holder _______________________________ S.S. # of Policy Holder _____________________________

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company ____ Policy #______________________

Name of Policy Holder _____________________________ Relationship to Patient _____________________________

DOB of Policy Holder ______________________________ S.S. # of Policy Holder _____________________________

MEDICAL INFORMATION RELEASE

I authorize the release of any medical information necessary to process an insurance claim and authorize direct payment to : The Central Orthopedic Group, LLP. I understand that I am financially responsible for treatment rendered.

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Signature of Patient or Authorized Representative: Date

GUARANTEE AGREEMENT

1. INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES
   In the event that I fail to provide the Central Orthopedic Group, LLP with valid No Fault information or if it is determined by the No fault Carrier that the condition is not a result of the accident as state above, I agree to pay for all medical services rendered to me by the Central Orthopedic Group, LLP.

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Signature of Patient or Authorized Representative: Date

UPDATED 3/2017