ST. CLAIR ORTHOPAEDICS AND SPORTS MEDICINE, P.C.

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45441 Heydenreich
Macomb, MI 48044
Phone (586) 416-1300
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Welcome to Our Practice

PATIENT INFORMATION

Patient Name: _____
Last Name First Name Initial

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Single: ____ Married: ____ Divorced: ____ Widowed: _____

Home Phone: _____ Alternate Phone: _____

EMail Address: _____

RACE/ETHNICITY

RACE

American Indian/Alaska Native
Asian
Black/African American
Nat Hawaiian/Pacific Islander
Other
Unknown
White/Caucasian

ETHNICITY

Hispanic/Latino
Not Hispanic/Latino

PRIMARY CARE PHYSICIAN / REFERRING PHYSICIAN

PCP Name: _____ Referring Name: _____

Phone Number: _____ Phone Number: _____

PHARMACY INFORMATION

Name: _____ City: _____

Crossroads: _____ Phone Number: _____

WORKER'S COMPENSATION/AUTO INSURANCE

*Is this visit related to an Auto Injury or Worker's Compensation Injury? (Circle) Yes No Auto W/C

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ Employer: _____

Policy Holder: _____ Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ Employer: _____

Policy Holder: _____ Date of Birth: _____

SHARING OF MEDICAL/ACCOUNT INFORMATION

Who May Pick Up Records or Discuss Care On Your Behalf? _____

Who May Speak On Your Behalf Concerning Your Billing Account? _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have made with the insurer).

Insurance companies DO NOT make us aware of all restrictions, such as pre-existing clauses, when we verify services. I am aware that if there is a pre-existing clause on my insurance plan, I may be responsible for anything that is not covered by my insurance company.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I HAVE RECEIVED NOTICE OF THIS ORGANIZATIONS PRIVACY PRACTICES.

Patient Signature: _____ Date: _____