

Genesee Orthopedics and Hand Surgery Assoc., PC

IF FORM NOT COMPLETELY FILLED OUT, BILLS WILL BE SENT DIRECTLY TO YOU

LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

AGE _____ DATE OF BIRTH ____/____/____ PHONE (____) ____ - _____ SSN _____

EMPLOYMENT:

EMPLOYER

ADDRESS _____ PHONE# _____

SPOUSE

EMPLOYER ADDRESS _____ PHONE# _____

FRIEND/RELATIVE NOT LIVING WITH YOU:

NAME : _____ RELATIONSHIP _____

ADDRESS _____ PHONE # _____

HAVE YOU EVER BEEN TREATED BY OUR DOCTORS BEFORE? YES __ NO __ DATE ____

FAMILY PHYSICIAN _____ ADDRESS _____

FOR CHILD:

FATHERS NAME & ADDRESS _____

FATHERS PHONE # (____) ____ - _____ SSN _____ DOB _____

FATHERS EMPLOYER _____

EMPLOYERS ADDRESS _____ PHONE# _____

MOTHERS NAME & ADDRESS _____

MOTHERS PHONE # (____) ____ - _____ SSN _____ DOB _____

MOTHERS EMPLOYER _____

EMPLOYERS ADDRESS _____ PHONE# _____

INSURANCE INFORMATION

DATE OF INJURY: _____ COMPENSATION __ NO FAULT __ MEDICARE ____

MEDICAID ____ PRIVATE INSURANCE ____

PRIVATE INSURANCE _____ ID # _____

Genesee Orthopedics and Hand Surgery Assoc., PC

ADDRESS _____
INSURED'S NAME _____ DOB _____ SS# _____
SECONDARY INSURANCE _____ ID# _____
ADDRESS _____
INSURED'S NAME _____ DOB _____ SS# _____

Assignment Of Benefits And Information

**any non-covered charge from insurance company is patient responsibility
collection fee will be added if placed for collection due to nonpayment which is patient
responsibility**

I authorize release of information from my records, even if it should contain alcohol, drug, HIV, or needs and information. I also understand that insurance forms are completely as a courtesy to me in that I am responsible for the unpaid balance or insurance nonpayment. I hereby authorize payment directly to Genesee Orthopedic and Hand Surgery, P.C.: Dr. Kenneth Kim, Dr. Peter Freedman, Dr. James Dennison, Dr. Andrew Wickline for services rendered.

SIGNATURE _____ DATE _____

Medicare Supplemental Assignment

I authorize older of medical information about me to release to (Medigap insurer) any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized Medigap benefits be made to Genesee Orthopedic and Hand Surgery Associates, PC: Dr. Kenneth Kim, Dr. Peter Freedman, Dr. James Dennison, Dr. Andrew Wickline.

SIGNATURE _____ DATE _____