

Chris J. DiGrado, M.D., M.B.A.
Ralph P. Katz, M.D.

Jeff D'Avy, P.T.
Robert Cox, P.T.A.

Fernando L. Sanchez, M.D.
David K. Kessler, M.D.

Thank you, for choosing Westside Orthopaedic Clinic. In order to serve you properly, we will need for you to complete this form.

PLEASE PRINT CLEARLY.

Reason for visit:

Work accident Accident Sports Injury Recurring Illness Other
If an accident, Date of accident ____/____/____? Place of accident: _____
Did you go to the hospital? Yes No If YES What hospital did you go to? _____

PATIENT

Last Name: _____ First: _____ M.I.: _____
Street Address 1: _____ Home Phone: (____) _____
Street Address 2: _____ Work Phone: (____) _____
City: _____ State: _____ Date of Birth: ____/____/____
Zip: _____ Sex: (M / F) _____ Social Security Number: _____ - _____ - _____
DRIVERS LICENSE #(Give license to receptionist) _____

1. Are you Employed YES NO? Are you a student YES NO? If YES Full Time Part-time
2. Marital status: Single Married Other?
3. Today's Date ____/____/____
4. Doctor who referred you to our clinic: _____
5. Which Doctor are seeing today? Dr. DiGrado Dr. Katz Dr. Kessler Dr. Sanchez

EMPLOYER (or Parents)

Name of Company: _____ Work Phone: (____) _____
Address 1: _____ Address 2: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT (Friend or Relative not living with you)

Name of Contact: _____ Phone / Cell / Beeper: (____) _____
Your relationship to emergency contact (mother, brother, uncle, etc...)? _____

SPOUSE INFORMATION

Spouse's name: _____ Phone / Beeper (if different) (____) _____
Employer: _____ Work Phone / Beeper: (____) _____

INSURANCE INFORMATION (Give insurance card to receptionist)

Primary Insurance: _____ ID or Policy # _____
Mailing address: _____ City _____ State _____ Zip _____
Name of Insured: _____ Group name: _____ Group #: _____

SECONDARY INSURANCE INFORMATION (Give insurance card to receptionist)

Secondary Insurance: _____ ID or Policy # _____
Mailing address: _____ City _____ State _____ Zip _____
Name of Insured: _____ Group name: _____ Group #: _____

CONSENT FOR TREATMENT: I as a patient consent to medical care including examination, diagnostic, or surgical treatment by the treating physician and such associates or assistants as may be deemed necessary. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of any treatment

Patient Signature _____ **Date** ____/____/____

AUTHORIZED RELEASE OF INFORMATION: I hereby authorize Westside Orthopaedic Clinic to release those medical records pertaining to my treatment to any entity that is responsible for payment of physician charges.. I understand that this authorizes my insurance company to pay any benefits direct to Westside Orthopaedic Clinic. In addition, I further understand that I am ultimately responsible for charges incurred for services rendered, and that *collection fees* will be added to balances not paid in a timely manner.

Patient Signature _____ **Date** ____/____/____