Manhattan Orthopaedics, P.C.

130 East 77th Street, 7th Floor
New York, New York 10075

www.manhattanorthopaedics.com
Tel: 212-744-8114
Fax: 212-472-5624

Patient Last Name:	**Patient First Name:**	**Gender:** □ Male □ Female
Patient Home Address:		
Patient Date of Birth:	**Patient Social Security Number:**	
Patient Cell Phone Number:	**Patient Home Number:**	**Patient Work Number:** Ext.
Employment Status: □ Full Time □ Part Time	**Occupation:**	
Employer Name:		
Employer Address:		
Are You a Full Time Student? □ Yes □ No	**School Attending:**	
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Significant Other		
Insurance Name:	**Insurance ID Number:**	
Policy Holder Name:	**Policy Holder Date of Birth:**	
Who Referred You To Our Office?		
Primary Care Physician:	**Primary Care Physician Phone Number:**	
In Case Of Emergency Please Notify: Name: Phone Number: Relationship:		

Authorization to Release Information and Financial Responsibility

I authorize the release of medical information pertaining to medical history and services rendered or treatment given to me or my dependents for purposes of review or investigation of this claim. I also acknowledge receipt of Manhattan Orthopaedics's HIPAA Privacy Notice. I further acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted. I authorize payment of surgical and/or medical benefits directly to the physician, and will forward to the physician any such benefits if they are paid directly to me. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, deductible and non-covered services.

X____ **Date** ____________________
Signature of Patient