

Casscells Orthopaedics & Sports Medicine, PA

2600 Glasgow Ave., Suite 104
Newark, DE 19702
(302) 832-6220

Patient Information

Name: _____ SS# _____
D.O.B. _____ Marital Status: _____ Sex: _____ Student Status: _____ Full _____ Part _____ None
Address: _____ City, State & Zip: _____
Home Phone: _____ Alt Phone: _____
Primary Care Physician: _____ Referring Physician: _____
Primary Employer: _____ Work Phone: _____
Address: _____ City, State & Zip: _____
Emergency Contact/Relationship: _____ Phone: _____

Responsible Party Information (If Different Than Above)

Name: _____ SS#: _____ D.O.B.: _____
Address: _____ City, State & Zip: _____
Home Phone: _____ Relationship to Patient: _____

(Primary Insurance)

Insurance Company: _____ Policy#: _____ Group/Acct#: _____
Subscriber's Name: _____ D.O.B.: _____ Relationship: _____

(Secondary Insurance)

Insurance Company: _____ Policy#: _____ Group/Acct#: _____
Subscriber's Name: _____ D.O.B.: _____ Relationship: _____

(Third Insurance - if applicable)

Insurance Company: _____ Policy#: _____ Group/Acct#: _____
Subscriber's Name: _____ D.O.B.: _____ Relationship: _____

I hereby authorize Casscells Orthopaedics and Sports Medicine, PA to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance. Once an amount is assigned as a patient balance, I will have 30 days to pay the amount before a 5% late fee will be assessed. If the patient is under 18 years of age, guarantor must sign.

Signature of Patient/Guardian

Date