

Lehigh Valley Institute for Sports & Musculoskeletal Medicine

NEW PATIENTS REGISTRATION – PLEASE COMPLETE ALL INFORMATION

Patient Name _____ SS# _____ Date _____

Date of Birth _____ Age _____ Marital Status (circle): S M D W Sep

Mailing Address _____ City _____ State _____ Zip _____

Street Address (if different) _____ City _____ State _____ Zip _____

Telephone: Home _____ Work _____ E-mail _____

Primary Care Doctor: Name _____ City _____ Phone _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Employer Address _____ Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Who referred you to our practice? (so we may thank them!) _____

PATIENT EMPLOYER INFORMATION

Employer Name _____ Phone _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID # _____ Group # _____ Eff Date _____

Policy Holder Name _____ SS # _____ Relationship _____ D.O.B. _____

Policy Holder Place of Employment _____ City _____ State _____ Zip _____

COMPLETE BELOW IF PERSONAL INJURY, CAR ACCIDENT, OR WORK INJURY

Attorney (if applicable) _____ Phone _____ Address _____

Insurance _____ Injury Date _____ Policy # _____

Claim Mailing Address _____ Contact Person _____ Phone _____

AUTHORIZATION TO RELEASE INFORMATION & TO ASSIGN BENEFITS

I authorize the release of any medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original.

I further authorize Dr. Frommer and/or staff of the Lehigh Valley Institute for Sports & Musculoskeletal Medicine to apply for benefits on my behalf for covered services rendered by him or by his order. I request that any payments from my insurance company be made directly to the Lehigh Valley Institute for Sports & Musculoskeletal Medicine or to Dr. Frommer. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either me or my insurance company at any time by written request.

I understand that, while insurance claims may be submitted as a courtesy by Dr. Frommer/Lehigh Valley Institute for Sports & Musculoskeletal Medicine on my behalf, I am ultimately responsible for all medical costs incurred as a result of my receiving treatment in this office.

Signature _____ Date _____

Patient (or Parent/Guardian)