WELCOME TO ORTHOPEDIC CARE CONSULTANTS- CARLOS ARROYO, PT
We hope your visit is helpful and pleasant. Please let us know if you have any questions or concerns.

DEMOGRAPHIC INFORMATION

NAME: (LAST, FIRST, MIDDLE) _____, _____, _____

HOME ADDRESS: _____APT: _____

CITY:_____ STATE: _____ZIP CODE: _____ SEX: MALE FEMALE

HOME TEL: _____ MOBILE: _____ WORK TEL: _____

DATE OF BIRTH: _____ SOCIAL SEC.#:_____ MARITAL STATUS: _____

EMAIL: _____ MAY WE EMAIL YOU OUR NEWSLETTER/ GENERAL HEALTH INFO? _____

OCCUPATION: _____ EMPLOYER: _____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE DOCTOR: _____ PRIMARY CARE DR. PHONE: _____

EMERGENCY CONTACT NAME: _____ EMERG. CONTACT PHONE: _____

PRIMARY INSURANCE: _____ ID #: _____ GROUP:_____

INSURED NAME: _____ RELATIONSHIP TO INSURED: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP: _____

INSURED NAME: _____ RELATIONSHIP TO INSURED: _____

To provide better service and avoid unnecessary out of pocket expenses, please answer the following.

Do you have a copayment? If so, what is the amount? _____

Do you have a deductible? If so, what is the amount? _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I HEREBY AUTHORIZE CARLOS ARROYO, PT TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PRACTICE (C/O THE OSMENT GROUP, LLC) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I AGREE THAT THIS AUTHORIZATION WILL COVER ALL MEDICAL SERVICES RENDERED UNTIL SUCH AUTHORIZATION IS REVOKED BY ME. I AGREE THAT ALL PHOTOCOPIES OF THIS FORM MAY BE USED IN LIEU OF THE ORIGINAL. I AGREE TO PAY ALL CHARGES NOT COVERED BY MY HEALTH INSURANCE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO: DEDUCTIBLE, COPAYMENTS AND/ OR CO-INSURANCE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL COLLECTION FEES AND I AM RESPONSIBLE TO NOTIFY THE OFFICE IF I HAVE A CHANGE IN INSURANCE OR LAPSE IN COVERAGE.

Signature: _____ Date: _____