SRINO BHARAM, M.D., P.C.

BOARD CERTIFIED ORTHOPEDIC SURGEON

154 W. 14TH STREET, FOURTH FLOOR
NEW YORK, NY 10011
TEL (212) 691-3535
FAX (212) 691-6370

INITIAL APPOINTMENT INFORMATION

Date: _____

Patient Name: _____
Last First Middle Marital Status

Home Address: _____
Street City State Zip

Home Tel. _____ Work Tel. _____ Cell Tel. _____

Emergency Contact (Name/Tel) _____Sex (M/F) ____ Date of Birth _____ Age _____

Social Security_____ Driver's License _____ State ____

Responsible Party _____
(If other than patient) Last First Middle Marital Status

Home Address: _____
Street City State Zip

Home Tel. _____ Work Tel. _____Sex (M/F) ____ Date of Birth _____ Age _____

Social Security_____ Driver's License _____ State ____

Condition Related to Illness ____ Auto Accident ____ Employment ____ Other ____ Date of Injury ____

Who Referred You: Physician ____ Friend ____ Ins. Co. ___ Attorney ____; phone _____ Other _____

Referrer Name _____
Name Address Telephone

Employer _____
Company Name Occupation Telephone

Address: _____
Street City State Zip

Insured's Name _____
Last First Middle

Home Address: _____
Street City State Zip

Relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

Insurance Information: _____
Insurance Company Telephone

Address: _____
Street City State Zip

I.D. # _____ Group # _____ Claim # _____

Primary Care Physician _____
Last First Middle

Address: _____
Street City State Zip

Patient Medical History

Please note the reason for today's visit: _____

_____

_____

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Please provide any additional medical information relevant to your current problem: _____

_____

_____

Date of Injury/Problem Began: _____ Side of body affected: Right ____ Left ____ Both ____

I am right handed ____ left handed ____

Please describe, with date, any serious injuries: _____

_____

_____

Patient Authorization

Claims Authorization – I hereby authorize any treating physician to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer('s) including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon my dependent's, and our heirs, executor's, administrators and me.

Assignment of Benefits – Private and Federal (Medicare) – I authorize payments of medical and surgical benefits, including Medicare benefits, to be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it s agents any information needed to determine these benefits payable for related services. I understand that any service deemed "Non-Covered" by my carrier are my sole financial responsibility, as outlined in my coverage manual. Prompt and complete payment of said services is also my sole responsibility.

Credit Card Authorization – I authorize, when requested by me over the phone, the use of my credit card for outstanding charges.

Litigation Disclaimer – It is understood and agreed that I am requesting examination and treatment for medical purposes.

Patient Name (print) _____

Patient Signature _____ Date _____