Name:
DOB:
Chart:
Age:
Date:

PATIENT INTAKE

WILMINGTON HEALTH
ORTHOPAEDICS AND SPORTS MEDICINE

Patient's Name:

Last: _____ First: _____ Middle Initial: _____DOB: _____

Side of body: ☐ LEFT ☐ RIGHT

CURRENT PROBLEM:

Describe your current problem: _____

_____

_____

When did this problem begin? _____Date: _____

Were X-Rays taken? ☐ Yes ☐ No If yes, where were they taken?_____

Did you bring these X-Rays today? ☐ Yes ☐ No Were you seen in the Emergency Room by our Doctor? ☐ Yes ☐ No

Have you previously been treated by a physician in this practice? ☐ Yes ☐ No If yes, approximately when?_____

Were you injured in an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other:_____

If accident related, describe how the injury occurred:_____

_____

_____

_____

_____

Do you have an attorney? ☐ Yes ☐ No If yes, Name:_____

Signature Authorizing Treatment: _____ Date:_____

INSURANCE ASSIGNMENT:

I, the undersigned, have insurance coverage and assign directly to Carolina Sports Medicine all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Signature of Insured/Guardian: _____ Date: _____

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to Carolina Sports Medicine for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, Carolina Sports Medicine agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____