Quality Orthopedics & Complete Joint Care, P.C.

Aleksandr Khaimov, D.O.

Cell Phone#: _____

Date _____ Home Phone _____

Name _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

INSURANCE INFORMATION

Primary Insurance Company _____ Policy Number _____ Group Number _____

Who is responsible for this account? _____ Relationship to Patient _____

Secondary Insurance Company _____ Policy Number _____ Group Number _____

Who is responsible for this account? _____ Relationship to Patient _____

Is your condition related to employment (current or previous)? No Yes

Is your condition related to an auto accident? No Yes Date of Accident _____

State where accident occurred _____

Other Accident? No Yes Please describe _____

NO- FAULT INSURANCE /WORKMAN'S COMPENSATION

Insurance Company _____ Phone _____

Insurance Co. Address _____

Claims Representative _____ Policy Holder _____

Policy Number _____ File Number _____

Attorney's Name _____ Phone _____

Attorney's Address _____

I hereby authorize Quality Orthopedics & Complete Joint Care to release all information necessary to secure the payment of benefits. I assign directly to Quality Orthopedics & Complete Joint Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature _____ Date _____