

TIER ORTHOPEDIC ASSOCIATES, P.C.

100 Plaza Drive - Vestal, New York 13850

Telephone 798-9356

Social Security No. _____

PATIENT INFORMATION

PATIENT NAME:

First Name _____ Middle Initial _____

Last Name _____

Patient's Address _____

City _____ Zip Code _____

Phone No. _____ Age _____ Date of Birth _____

Sex: Male _____ Female _____

Primary Care Physician/Referring Physician:

Patient's Employer _____

Work Phone _____

Spouse's Name or Nearest Relative _____

Address _____

Phone No. _____

Employed by _____

IF CHILD:

Parent's Name _____

Employed by _____

WHAT ARE YOU BEING SEEN FOR?

Right _____ Left _____ Body Part _____

WERE X-RAYS TAKEN? Yes ___ No ___ Where _____ When _____

WERE MRI'S TAKEN? Yes ___ No ___ Where _____ When _____

WAS EMG DONE? Yes ___ No ___ Where _____ When _____

INSURANCE INFORMATION:

WERE YOU INJURED AT WORK?

Yes ___ No ___ Date of injury _____

Comp Carrier _____

WERE YOU INJURED IN AN AUTO ACCIDENT?

Yes ___ No ___ Date of Accident _____

PRIMARY INSURANCE CO. _____

ID No. _____

Subscriber _____

SECONDARY INSURANCE CO. _____

ID No. _____

Subscriber _____

OFFICE USE ONLY

DOCTOR _____

DATE SEEN _____

Initial _____

MEDICAL INSURANCE WAIVER

I, THE UNDERSIGNED, AGREE TO THE PROVISION THAT IF MY MEDICAL INSURANCE DOES NOT COVER ANY AND ALL EXPENSES INCURRED DURING THE COURSE OF MY MEDICAL TREATMENT, I AM RESPONSIBLE FOR SAID PAYMENTS.

PATIENT OR GUARDIAN SIGNATURE

DATE _____

Payment Authorization to Provider _____

FOR OFFICE USE ONLY Account No. _____

X-Ray No. _____