

# Howard J. Gelb, M.D., P.A., F.A.A.O.S

Adult and Pediatric Orthopedic Surgery

Board Certified and Fellowship Training in Sports Medicine & Arthroscopic Surgery

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(Please Print) – Please fill out completely as possible

Name (First): \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Driver's License State: \_\_\_\_\_ Occupation: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer/School: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Permanent Resident Yes No If no, Please list 2nd address.

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If patient is a minor - please complete:

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Position: \_\_\_\_\_ Phone: \_\_\_\_\_ Position: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list the name of a person to contact in case of an emergency other than a spouse or parent:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

## PRIMARY INSURANCE – please have insurance cards ready to be copied

Name of Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ID#: \_\_\_\_\_ Group No.: \_\_\_\_\_

Insured's Full Name: \_\_\_\_\_ Is this an Employer's Plan? Yes No

Insured Soc. Sec. No. \_\_\_\_\_ Insured D.O.B. \_\_\_\_\_

Relationship to Insured (self, spouse, child, other): \_\_\_\_\_

## SECONDARY INSURANCE – please have insurance cards ready to be copied

Name of Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ID#: \_\_\_\_\_ Group No.: \_\_\_\_\_

Insured's Full Name: \_\_\_\_\_ Is this an Employer's Plan? Yes No

Insured Soc. Sec. No. \_\_\_\_\_ Insured D.O.B. \_\_\_\_\_

Relationship to Insured (self, spouse, child, other): \_\_\_\_\_

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION/FINANCIAL AGREEMENT. I, the undersigned, knowing the patient, (minor) and/or self, is suffering from a condition requiring health care, diagnosis and/or medical treatment hereby voluntarily agree to such diagnostic procedure and health care and assignees. I authorize the release of medical information to my referring doctor, health agency, government agency, insurance company or worker's compensation. I request that payment to insurance benefits made on my behalf be paid directly to the doctor. I assume full financial responsibility for all debts incurred in any treatment and follow-up care received. I understand that no guarantee or assurance has been made as to the results of the procedure or treatment and that it may not cure the condition. It is the patient's responsibility to obtain authorization from their Primary Care Physician or insurance company (if required by your insurance company) prior to services being rendered.

Patient's or Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_