Patient Face Sheet

Noss-Waterbury
500 CHASE PARKWAY
WATERBURY, CT 06708 - 3346

Revised 12/01/15

Account Number: Reference/Medical: Date Printed:

Patient Information

Last Name: First Name: MI

S.S. Number: Sex: ☐ Male ☐ Female

Address:

City: State Zip Code: Primary Care Physician:

Home Phone: Work Phone: Cell Phone:

Birth Date: Age: E-MAIL

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

ReferringProvider: Name: Phone Fax

Race: ☐ White ☐ Other ☐ Hispanic Black **Ethnicity:** ☐ Hispanic Origin ☐ **Patient Declined**

☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Non-Hispanic Origin

☐ Hispanic ☐ Type-Unknown

☐ Asian ☐ Hispanic White ☐ Type-Unknown **Language:**

Primary Insurance Information

Primary:
Insured Name:
Birth Date:
Identification Number:
Group/Policy Number:
Employer Name:

Secondary Insurance Information

Secondary:
Insured Name:
Birth Date:
Identification Number:
Group/Policy Number:
Employer Name:

Attorney Information

Attorney Name:
Street:
City:
State: Zip:
Phone Number:

Patient Employer Information

Employer's Name:
Address:
City:
State: CT Zip Code:
Phone:
Occupation:

Please Complete Below if Applicable to Today's Visit:

☐ Workman's Compensation Have you reported this injury to your employer? ☐ Yes ☐ No

☐ Liability ☐ Auto

Date of Injury:

If you have hired an attorney for this injury please complete the Attorney Information Section above.

Pharmacy Name:
Phone:
Address:
City:

(HIPAA RELEASE: I authorize NOSS to discuss my Health Information with my Family member(s) and/or Friend(s) listed:

Name Phone Relation

Name Phone Relation

PLEASE COMPLETE REVERSE SIDE

Signed (Patient or Parent if Minor) Date

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Account Number: Reference/Medical: Date Printed:

Last Name: _____ First Name: _____

PLEASE READ EACH STATEMENT BELOW
INITIAL, SIGN AND DATE AS AUTHORIZATION

I, the undersigned, give my authorization to treat and assign directly to Neurosurgery, Orthopaedics & Spine Specialists, PC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hearby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

Please inital upon acceptance: ☐

I authorize the Practice to use and disclose my health information for purposes of treating MD, obtaining payment for services rendered to me, and conducting healthcare operations.

Please inital upon acceptance: ☐

You acknowledge and agree that by signing this form, you are providing prior, express consent for NOSS, and it's providers, agents, contractors, and collection agencies to place calls to your designated cellular or residential phone using any type of artificial or pre-recorded voice or auto-dialer technologies for any purpose permitted by law.

Please inital upon acceptance: ☐

I agree that Neurosurgery, Orthopaedics & Spine Specialists, PC may request and use my prescription medication history from other healthcare providers.I acknowledge that a copy of the Practice's Notice of Privacy Practices was made available to me .

Please inital upon acceptance: ☐

Revised 12/01/15

_____ _____

Signed (Patient or Parent if Minor) Date