Orthopedic Specialists & Sports Medicine
KEEPING YOU ACTIVE

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Edward L. Westerheide, M.D.
Brad L. Bernacki, M.D.
Alex Tancevski, M.D.

Last Name: _____ First Name: _____ MI: ___ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ DOB: _____ Sex: ❒ M ❒

F Message: Home ❒ Cell ❒ Other Residents ❒ Whom may we contact about medical concerns? _____

Referring Physician: _____ Patient Email: _____

Primary Physician: _____ Primary Physician Phone: _____

Employer: _____ Employer Phone: _____

Emergency Contact: _____ Emergency Contact Phone: _____ Relationship: _____

Employment Status: ❒ Full ❒ Part ❒ Retired ❒ Unemployed Marital Status: ❒ Single ❒ Married ❒ Divorced

Do you have any advanced directives/living will? ❒ Yes ❒ No ❒ Widowed ❒ Separated

Responsible Party Information

Last Name: _____ First Name: _____ MI: ___ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ DOB: _____ Sex: ❒ M ❒ F

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance: _____ Policy No.: _____ Group No.: _____

Policy Holder: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City: _____ State: _____ Zip: _____

Relation to Patient: _____ Co-Pay: _____

Other Insurance: _____ Policy No.: _____ Group No.: _____

Policy Holder: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City: _____ State: _____ Zip: _____

Relation to Patient: _____ Co-Pay: _____

Today's Visit

Was this an injury? ❒ Y ❒ N Auto accident? ❒ Y ❒ N Work-related? ❒ Y ❒ N BWC Claim No.: _____

Date of Injury: _____ Employer at Time of Injury: _____ Employer Phone: _____

I understand and request that payment of authorized insurance company benefits be made directly to Orthopedic Specialists & Sports Medicine on my behalf for all rendered services. I authorize any holder of medical information about me to release information needed to determine these benefits or for benefits payable to related services or as requested by my insurance company. I am responsible for any co-pay, co-insurance, deductible, and non-covered amounts. I also give permission for my prescription history to be obtained by Orthopedic Specialists & Sports Medicine. HIPAA: I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Orthopedic Specialists & Sports Medicine, Inc. Notice of Privacy Practices.

Responsible Party Signature: _____ Date: _____

How did you hear about us?

❒ Yellow Pages ❒ Internet ❒ Friend/Family ❒ Primary Care ❒ Newspaper ❒ Radio ❒ Hospital/ER/Urgent Care

❒ Other: _____