

JONATHAN L. GLASHOW, M.D., P.C.
Clinical Associate Professor
Co-Director, Sports Medicine Service
Department of Orthopaedic Surgery
Mount Sinai Medical Center

DATE:

PATIENT INFORMATION

PLEASE PRINT

PATIENT NAME: _____
(Last) (First) (Middle)

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **OFFICE PHONE:** _____

SOCIAL SECURITY # _____ **DATE OF BIRTH:** _____ **SEX (CIRCLE):** MALE FEMALE

EMERGENCY CONTACT NAME: _____ **PHONE :** _____

NEXT OF KIN: _____ **RELATIONSHIP TO PATIENT:** _____ **PHONE:** _____

OCCUPATION: _____ **EMPLOYER:** _____

BUSINESS ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

EMAIL ADDRESS _____

WHO REFERRED YOU TO DR. GLASHOW? _____

(IF THIS IS A WORK RELATED INJURY OR N.Y. STATE AUTO ACCIDENT INJURY, PLEASE SEE THE RECEPTIONIST).

INSURANCE: _____ **POLICY #** _____ **GROUP#** _____

SECONDARY INSURANCE: _____ **POLICY #:** _____ **GROUP#** _____

IS THIS A LITIGATION CASE? YES NO

If this is your spouse's or parent's insurance policy, please provide the following information.

SPOUSE / PARENT NAME: _____ **DATE OF BIRTH:** _____ **SOCIAL SECURITY #:** _____

(Address of insured if different than the patient's address)

_____ **CITY** _____ **STATE** _____ **ZIP** _____

Medicare Patients: This practice has opted out of Medicare as of June 2004. Medicare information is used for denial purposes only.

Medicare Patients please see the receptionist for a private contract waiver.

DR. GLASHOW IS NOT A PARTICIPATING MEMBER OF ANY INSURANCE COMPANY. As a private patient, we will bill your insurance carrier and balance bill you for any deductibles or coinsurance. Thank you in advance for your cooperation. I understand and agree that I am responsible for payment if my insurance carrier does not cover any portion of my visit. _____

Signature

Date

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WORKMEN'S COMPENSATION INFORMATION

PATIENT NAME: _____

DATE OF INJURY: _____ EMPLOYER _____

WORKMEN'S COMPENSATION INSURANCE COMPANY: _____

INSURANCE CARRIER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY PHONE: _____ CLAIM REPRESENTATIVE: _____

POLICY OR CLAIM NUMBER: _____ WCB NUMBER: _____

IN THE EVENT IF I FAIL TO PROSECUTE THE CLAIM FOR WORKMEN'S COMPENSATION FOR THIS ILLNESS OR CONDITION OR IT IS DETERMINED BY THE WORKMEN'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKMEN'S COMPENSATION CASE, I, _____ HEREBY AGREE TO PAY CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.

SIGNED: _____ DATE: _____

IS THIS A LITIGATION CASE? _____

ATTORNEY'S NAME: _____

ATTORNEY'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER _____

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Shoulder/Elbow, Knee Surgery

IS THIS A New York STATE NO-FAULT (AUTO ACCIDENT) CASE? (CIRCLE): YES NO
IS THIS A NO-FAULT CASE OUT OF NEW YORK STATE? (CIRCLE): YES NO

PATIENT NAME: _____

DATE OF ACCIDENT: _____

INSURANCE CARRIER: _____

INSURANCE CARRIER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

I HAVE FILED A CLAIM WITH MY NO FAULT INSURANCE CARRIER YES NO

MY CLAIM IS CURRENTLY ACTIVE YES NO

CLAIM NUMBER: _____

I HEREBY AUTHORIZE PAYMENT OF BENEFITS UNDER THE NO-FAULT INSURANCE PLAN TO BE PAID DIRECTLY TO JONATHAN L. GLASHOW, M.D. FOR SERVICES RENDERED TO ME AS A RESULT OF THIS ACCIDENT.

SIGNED: _____ DATE _____

I HEREBY GIVE AUTHORIZATION TO JONATHAN L. GLASHOW, M.D. TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE NO-FAULT CARRIER.

SIGNED: _____ DATE _____

IN THE EVENT THAT MY NO FAULT CARRIER DENIES COVERAGE OF MY MEDICAL EXPENCES, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

SIGNED: _____ DATE _____

IS THIS A LITIGATION CASE? YES NO

ATTORNEY'S NAME: _____

ATTORNEY'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER _____

Shoulder/Elbow, Knee Surgery