Monadnock Orthopaedic Associates, PLLC

458 Old Street Road
Wellness Center, Suite 200
Peterborough, NH 03458

phone: 603.924.2144
fax: 603.924.3993

NAME: _____DOB:_____ SS#_____
(Last Name, First Name, Initial)

Address: _____ _____(Street)

_____ (City, State, Zip Code)

Phone (home)_____(cell)_____(work)_____

Email Address: _____

Emergency Contact (Name/Phone):_____

Primary Care Physician: _____ Referring Physician:_____

Primary Insurance: _____

Subscriber Name: _____ DOB:_____

Secondary Insurance:_____

Is this visit the result of a work injury or motor vehicle accident? Yes No

I authorize Monadnock Orthopaedics to render care appropriate to diagnose and/or treat my condition. I understand that no guarantee has been made to me about the outcome of treatment. I may stop my request for treatment at any time.

I hereby authorize Monadnock Orthopaedics to leave medical information whenever necessary on answering machines and/or email, realizing that once left, the information may not be secure, and to speak to the individuals listed below regarding my medical condition:

_____ _____
(Name of family/friend) (Name of family/Friend)

I understand that if my insurance company requires a referral from my primary care provider, I am responsible to obtain one. I also understand that if a referral is not obtained, that all charges incurred for my medical care will ultimately be my responsibility.

I hereby authorize the release of information necessary to file claims with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am legally responsible for any balance not covered by my insurance. I understand I may get separate bills from Monadnock Orthopaedics and Monadnock Community Hospital as part of my treatment and am responsible for payment of associated bills.

I acknowledge receipt of, or have been given access to, the Monadnock Community Hospital Privacy Notice, Patient Rights Brochure and Advanced Medical Directives.

_____ _____
(Signature of Patient/Representative) (Date)