Monadnock Orthopaedic Associates, P.C.

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)_____

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 Orthopaedic 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 my treatment. I may stop my request for treatment at any time.

I hereby authorize Monadnock Orthopedics to leave medical information whenever necessary on answering machines and/or email, realizing that once left, the information may not be secure.

I hereby authorize Monadnock Orthopedics 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 authorize Monadnock Orthopedics to release medical information to any insurance company in order to pay for services rendered to me.

I acknowledge receipt of the Monadnock Orthopedic Notice of Health Information Practices and No-Show policy.

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