ADVANCED ORTHOPEDICS

Leonard Karadimas, D.O.
Timothy Lukas, M.D.

Knee & Shoulder Specialists

Board Certified Orthopedic Surgeons
Sports Medicine Specialists

**Patient Information**

Last Name_____First_____M.I_____ Male_____ Female_____

Date Of Birth_____/_____/_____ Age_____ Social Security #_____

Home Address_____City_____State_____Zip_____

Mailing Address (If Different)_____City_____State_____Zip_____

Home Phone(____)_____Cell(____)_____Work(____)_____

Marital Status: Single_____ Married_____ Widowed_____ Divorced_____ Race_____

Employer_____ Occupation_____ Full Time_____ Part Time_____

Employer Address_____City_____State_____Zip_____

School Name_____ Full Time_____ Part Time_____

Primary Care Physicians Name_____

Would you like your records sent to your physician? Yes_____ No_____

**Emergency Contact**

Name_____Relationship_____Phone(____)_____

Whom may we talk to about your care? _____

**Insurance**

**Was this injury sustained on the job? Yes_____ No_____ Was a claim filed? Yes_____ No_____**

*Primary Insurance*_____ Subscriber Name_____

Subscriber Date Of Birth_____/_____/_____ Male_____ Female_____

Subscriber Address (If different from patient)_____

Relationship to Patient_____ Subscriber Employer_____

*Secondary Insurance*_____ Subscriber Name_____

Subscriber Date Of Birth_____/_____/_____ Male_____ Female_____

Subscriber Address (If different from patient)_____

Relationship to Patient_____ Subscriber Employer_____

See reverse side…

**Guarantor** (If patient is a minor)

Last Name_____First_____M.I_____ Male_____ Female_____

Date Of Birth_____/_____/_____ Age_____ Social Security #_____

Home Address_____City_____State_____Zip_____

Home Phone(____)_____Cell(____)_____Work(____)_____

**Consent For Treatment:** I hereby consent to necessary examination, procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

**Financial Responsibility:** I acknowledge full financial responsibility for services rendered. I also understand that payment of charges incurred is due at time of services.

**Authorization To Release Information:** I hereby understand and acknowledge I have been provided with a *Notice of Privacy Practices*. I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.

**Assignment Of Benefits:** I hereby authorize my insurance benefits to be paid directly to *Advanced Orthopedics*. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature (Parent or Guardian if child is a minor)_____

Date_____