

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

PATIENT INFORMATION

DATE: _____

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

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE _____ OFFICE PHONE _____

SOCIAL SECURITY # _____ DATE OF BIRTH: _____ MALE _____ FEMALE _____

OCCUPATION: _____ EMPLOYER: _____

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

EMAIL ADDRESS _____

WHO REFERRED YOU TO DR. GLASHOW? _____

EMERGENCY CONTACT NAME: _____ CONTACT INFO: _____

NEXT OF KIN: _____ RELATIONSHIP TO PATIENT _____

(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

RELEASE: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZED THE RELEASE OF ANY MAEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature

Date

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES.

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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NO-FAULT INFORMATION

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 _____