

Mark E. Einbecker, M.D.  
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A Division of Ortho Kentucky, PLLC

**All information is strictly confidential.**

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**Patient Information**

Name \_\_\_\_\_

Home phone \_\_\_\_\_ cell phone \_\_\_\_\_ work phone \_\_\_\_\_

Address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_ zip \_\_\_\_\_

Email \_\_\_\_\_

Do you currently reside in or on temporary leave from a nursing facility? \_\_\_\_\_

If so, please provide the nursing homes address and phone # below:

\_\_\_\_\_

Birthdate \_\_\_\_\_ age \_\_\_\_\_ sex \_\_\_\_\_ marital status \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Employer phone \_\_\_\_\_

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**Worker's Compensation/Auto Information**

Is your injury work/auto related? yes no Date of injury: \_\_\_\_\_

If so has a claim been filed? yes no Place of accident/injury: \_\_\_\_\_

Claim # \_\_\_\_\_ Contact name: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

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**Insurance Subscriber Information**

Name \_\_\_\_\_

Home phone \_\_\_\_\_ cell phone \_\_\_\_\_ work phone \_\_\_\_\_

Address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_ zip \_\_\_\_\_

Birthdate \_\_\_\_\_ SS # \_\_\_\_\_ relationship to patient \_\_\_\_\_

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**Insurance Information (must have card at registration)**

Primary insurance \_\_\_\_\_ policy # \_\_\_\_\_

Group # \_\_\_\_\_ address \_\_\_\_\_

Other insurance \_\_\_\_\_ policy # \_\_\_\_\_

Group # \_\_\_\_\_ address \_\_\_\_\_

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**PLEASE COMPLETE REVERSE SIDE AND SIGN  
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**Emergency contact (nearest relative friend not living with you)**

Name \_\_\_\_\_ cell phone \_\_\_\_\_ home phone \_\_\_\_\_

Address \_\_\_\_\_ relationship \_\_\_\_\_

**Consent for treatment**

I, hereby give my permission for Drs. Einbecker, P. Nicholls, DeGnore, and M. Nicholls to render treatment to me/my dependent. I understand that I will be given all available pertinent information, prior to treatment being rendered. I understand that I may decline recommendation treatments at anytime, but that if I choose to do so, it is at my own medical risk.

Signed \_\_\_\_\_ date \_\_\_\_\_

**Consent to release/obtain medical information**

Permission is, hereby, granted to Drs. Einbecker, P. Nicholls, DeGnore, and M. Nicholls to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment, and/or my referring family physician. Permission is hereby, granted to any facility where I have previously been treated to release medical records/x-rays to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls.

Signed \_\_\_\_\_ date \_\_\_\_\_

**Authorization for payment of benefits**

I authorize insurance payment benefits to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls for service rendered. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

Signed \_\_\_\_\_ date \_\_\_\_\_

**Medicare patients only**

I authorize payment of Medicare benefits to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls for services rendered, and I authorize the release of medical information to Health Care Finance Administration (HCFA) and/or its agents. I have received the supplier standards information sheet.

Signed \_\_\_\_\_ date \_\_\_\_\_