CAPITAL ORTHOPAEDIC SPECIALISTS

Richard P. DuShuttle, M.D. David E. Eakin, D.O. Cynthia Devine, APRN, CNP

Patient Name:____________________________________Age:___Date of Birth:___________________________

Address:____City/State/Zip:________________________________

Home Phone:________________Cell Phone:___________ Social Security:_______________________________

E-Mail Address:____Gender: Male____Female______

Race____________________________________ Martial Status: Single____Married____ Other______________

Employer:______________________________ ______Work Phone #___________________________________

Spouse:_________________________________ Phone #____

Parent Name(if under 18)_______________ ________Phone #____

Referring Physician:______________________Primary Care Physician___________________________________

INSURANCE INFORMATION

Primary Insurance
(Please check one)

___Health Insurance
___Auto Accident
___Workman's Comp
___Other

Company Name:____
Address:____
Adjuster:_________________________ Phone #___________________________
ID #___________________ Group #_____________________________________
Policy:_________________ _____Claim #_________________________________

Secondary Insurance
(Please check one)

___ Health Insurance
___ Auto Accident
___ Workman's Comp
___ Other

Company Name:____
Address:____
Adjuster:_____________________ Phone #_______________________________
ID #___________________ Group #_____________________________________
Policy:________________ ______Claim #_________________________________

Date of Injury:
Do you have an Attorney?_____ Attorney Name:____
Attorney Phone #____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby authorize Dr. DuShuttle and/or his representative to furnish information to my insurance carriers concerning my illness/injury and treatment. I hereby assign to Richard P. DuShuttle, MD, P.A., David E. Eakin, D.O. and Cynthia Devine, APRN, CNP any all payments for medical services rendered to myself and/or dependents. I understand that I am responsible for any amount not covered by my insurance. I also understand that if my account is turned over to a collection agency and/or legal counsel, I will be responsible for any collection and/or legal fees incurred in addition to the office charges.

SIGNATURE:____ DATE:_____________________________

WORKMAN'S COMPENSATION AUTHORIZATION

I authorize the release of medical information regarding my work injury sustained on____________________________
to my employer____.

SIGNATURE:____ ________Date:__________________________