

**HAMPSHIRE ORTHOPEDICS AND SPORTS  
MEDICINE, INC.**  
4 West Street - West Hatfield, MA 01088  
(Tel) 413-586-8200 - (Fax) 413-582-1460  
www.hampshireorthopedics.com

<b>AUTO ACCIDENT</b>	_____	<b>YES</b>	_____	<b>NO</b>
<b>WORK</b>	_____	<b>YES</b>	_____	<b>NO</b>
<b>OTHER</b>	_____	<b>YES</b>	_____	<b>NO</b>
<b>INJURY DATE:</b>	_____			
<b>INJURY LOCATION:</b>	_____			
<b>WHO REFERRED YOU:</b>	_____			

**ACCOUNT #**

<b>DATE:</b>	<b>PATIENT INFORMATION</b>		
Last Name	First Name	MI	
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Date of Birth	SSN	Sex (M/F)	
Primary Care Physician (PCP)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		
Employer Name	Employer Phone		
Employer Address	City	State	Zip
<b>RESPONSIBLE PARTY INFORMATION</b>			
Name	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Street Address	City	State	Zip
Home Phone	Employer Name		
Work Phone	Employer Address		
<b>PRIMARY INSURANCE INFORMATION</b>			
Insurance Company Name	Phone		
Street Address	City	State	Zip
Policy #	Group#	Plan #	
Patient's Relationship to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Subscriber Name	Subscriber DOB		
Subscriber Address	Subscriber SSN		
Subscriber Employer			
<b>SECONDARY INSURANCE INFORMATION</b>			
Insurance Company Name	Phone		
Street Address	City	State	Zip
Policy #	Group#	Plan #	
Patient's Relationship to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Subscriber Name	Subscriber DOB		
Subscriber Address	Subscriber SSN		
Subscriber Employer			
<b>EMERGENCY CONTACT INFORMATION</b>			
Name	Relationship to Patient		
Home Phone	Work/Cell#		

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Hampshire Orthopedics and Sports Medicine, Inc., to release any information acquired in the course of my examination or treatment to my insurance carrier.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Patient or Parent if Minor)

**AUTHORIZATION TO PAY BENEFITS:** I hereby authorize payment directly to Hampshire Orthopedics and Sports Medicine, Inc., of all Surgical and/or Medical Benefits, if any, otherwise payable to me for their services. I understand that I am financially responsible for charges not covered by this insurance.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Insured Person)