

Plymouth  
ORTHOPEDICS & SPORTS  
MEDICINE CLINIC  
*A practice of Speare Memorial Hospital*

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ SS#: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WK PH: (\_\_\_\_) \_\_\_\_\_

PRIMARYCARE PHYSICIAN \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PH: (\_\_\_\_) \_\_\_\_\_ WK PH: (\_\_\_\_) \_\_\_\_\_

PLEASE HELP US VERIFY YOUR INSURANCE INFORMATION: Is your injury/problem related to...

Check one: No accident \_\_\_\_\_ Work accident \_\_\_\_\_ Auto accident \_\_\_\_\_

**Primary Ins. Co:** \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to insured: \_\_\_\_\_ Insured's Employer; \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Worker's Comp ins. Co** \_\_\_\_\_ Claim #: \_\_\_\_\_

Address: \_\_\_\_\_

Case manager: \_\_\_\_\_ Phone: \_\_\_\_\_

**Auto Ins. Co** \_\_\_\_\_ Policy # \_\_\_\_\_

Address: \_\_\_\_\_

Policy holder: \_\_\_\_\_ Accident date \_\_\_\_\_

Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to COTTAGE ORTHOPEDICS, PLLC, for services provided. I understand that it is my responsibility to obtain a referral from my primary care physician for this visit. I understand that I am responsible for any co-pays and charges not covered by my insurance.

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SIGNATURE OF PATIENT/PARENT/GUARDIAN

DATE