ESSEX ORTHOPAEDICS &
OPTIMA SPORTS MEDICINE

16 Pelham Road, Suite 1
Salem, NH 03079
PH: (603) 898-2244
FAX: (603) 898-2227

PATIENT INFORMATION

PATIENT NAME: _____ SS#: _____-_____-_____

HOME ADDRESS: _____
STREET CITY STATE ZIP

DATE OF BIRTH: _____/_____/_____ EMAIL ADDRESS: _____

MARITAL STATUS: _____ GENDER: _____ MALE _____ FEMALE

HOME PHONE: _____-_____-_____ WORK PHONE: _____-_____-_____ CELL PHONE: _____-_____-_____

LANGUAGE: _____ RACE: _____ ETHNICITY: _____ **DECLINE** ☐

WE ARE REQUIRED BY THE FEDERAL GOVERNMENT TO ASK THE ABOVE INFORMATION. YOU MAY CHOOSE NOT TO ANSWER THESE QUESTIONS.
YOUR CARE WILL NOT BE AFFECTED BY YOUR CHOICE TO ANSWER OR NOT ANSWER THESE QUESTIONS

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

WORK ADDRESS: _____
STREET CITY STATE ZIP

NAME OF PRIMARY CARE PHYSICIAN: _____

PCP ADDRESS: _____
STREET CITY STATE ZIP

CONSULTATION REQUESTED BY DR: _____

PREFERED PHARMACY: _____

ADDRESS: _____ PHONE: _____-_____-_____
STREET CITY STATE ZIP

PROBLEM DESCRIPTION -- WHY ARE YOU SEEING THE DOCTOR? _____
CIRCLE: LEFT RIGHT

IS THIS PROBLEM THE RESULT OF AN ACCIDENT? NO _____ YES _____ DATE OF ACCIDENT: _____/_____/_____

DID THIS OCCUR: AT WORK _____ AUTO _____ OTHER _____ EXPLAIN: _____

INSURANCE INFORMATION

SUBSCRIBER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS (IF DIFFERENT FROM PATIENT): _____
STREET CITY STATE ZIP

SUBSCRIBER'S SS#: _____-_____-_____ SUBSCRIBER'S DOB: _____/_____/_____

PRIMARY INSURANCE: _____

MEMBERSHIP/ID/CERTIFICATE #: _____ GROUP #: _____

SECONDARY INSURANCE: _____

MEMBERSHIP/ID/CERTIFICATE #: _____ GROUP #: _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO COMPLETE THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO ESSEX ORTHOPAEDICS & OPTIMA SPORTS MEDICINE. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY SERVICES NOT COVERED BY MY INSURANCE.

SIGNATURE: _____ DATE: _____/_____/_____

I AUTHORIZE ESSEX ORTHOPAEDICS & OPTIMA SPORTS MEDICINE TO DOWNLOAD MY MEDICATION HISTORY FOR THE PAST 13 MONTHS FROM MY INSURANCE COMPANY.

SIGNATURE: _____ DATE: _____/_____/_____

I ACKNOWLEDGE RECEIPT OF THE ESSEX ORTHOPAEDICS & OPTIMA SPORTS MEDICINE PLLC NOTICE OF PRIVACY PRACTICES.

SIGNATURE: _____ DATE: _____/_____/_____