

The Orthopaedic Center of SW Florida, PLLC

-Please Print-

Patients' Name _____
(LAST) (FIRST) (MIDDLE)

Local Address _____ City _____ State _____ Zip _____

Other Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Best number to reach me is my (circle one): Home Cell Work

Age ____ Date of Birth ____/____/____ (M/D/Y) Sex ____ Social Security # _____

Marital Status _____

*****If patient is under 18, please give:

Parent or guardian name: _____ Social Security # _____

Parent or Guardian Address: _____ Phone: (____) _____

Employer: _____ Address: _____

Work Phone: (____) _____ Occupation: _____

Spouses' name: _____ Spouses' Employer: _____

Person to contact in an emergency, other than spouse: _____ Phone: (____) _____

*****PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD(S) *****
*****AND DRIVER LICENCE TO COPY FOR YOUR RECORDS*****

ALL UNPAID BALANCES WILL BE CONSIDERED DELINQUENT **THIRTY (30)** DAYS AFTER DATE OF CHARGE *UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.*

ANY DELIQUENT ACCOUNT REFERRED TO A COLLECTION AGENCY WILL BE FULLY RESPONSIBLE FOR THE COST OF COLLECTION INCURRED BY THE ORTHOPAEDIC CENTER, INCLUDING ATTORNEY'S FEES.

I HEREBY AUTHERIZE MY INSURANCE COMPANY, INCLUDING PRIVATE MEDICAL INSURANCE AND ANY OTHER HEALTH PLAN, TO PAY BENEFITS TO WHICH I AM ENTITLED FOR OFFICE CHARGES OR SURGICAL PROCEDURES TO **CHRISTOPHER R. SFORZO, M.D.**

I AUTHERIZE MY PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT NECESSARY TO SECURE PAYMENT. I HEREBY AGREE THAT MY PHYSICIAN OR HIS DESIGNATE MAY SHARE HEALTH INFORMATION WITH OTHER PHYSICIANS WHEN SUCH SHARING IS NECESSARY FOR MY TREATMENT.

PRESCRIPTIONS WILL BE RENEWED ONLY DURING BUSINESS HOURS, **M-F BETWEEN 9 AM AND 4 PM.** PRESCRIPIONS WILL **NOT** BE FILLED AFTER HOURS, AT NIGHT, ON WEEKENDS OR HOLIDAYS. PLEASE ANTICIPATE WHEN YOU WILL NEED A REFILL BEFORE YOUR NEXT APPOINTMENT. *PLEASE ALLOW 2-3 BUSINESS DAYS TO RENEW YOUR PRESCRIPTIONS.*

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES _____
(PATIENT OR GUARDIAN SIGNITURE)