

MANHATTAN ORTHOPEDIC & SPORTS
MEDICINE GROUP, P.C.

EDMOND CLEEMAN, M.D.
MARVIN S. GILBERT, M.D.
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MARK J. KLION, M.D.
NADYA SWEDAN, M.D.
VIKAS VARMA, MD

Please Print

Name _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone _____ Work # _____

E mail address: _____ Cell# _____

Do we have permission to email you? YES NO

Birth Date _____ Age _____ SS# _____

Please Circle: Female Male Married Single Divorced Widowed

Occupation _____ Employer _____

In Case of Emergency, Please Contact:

Name _____ Phone # _____ Relationship: _____

Primary Physician: _____ Phone _____

Address _____ City/St. _____ Zip _____

Referred by: _____

Is injury Job related or due to car accident: YES NO

If yes: Date of accident _____

Medical Insurance: Please present your Insurance ID cards to the receptionist

Primary Coverage _____

Insureds name, if not the same _____ SS# _____ DOB _____

Secondary Coverage _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Manhattan Orthopedics & Sports Medicine, P.C. for services described. I accept full responsibility for total amount of bill. I understand that if anything above is untrue, I am responsible for the full bill. If payment is not made on time I am responsible for a finance charge.

Signed: _____ Date: _____

MEDICARE INFORMATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or their intermediaries or carriers, or to the billing agent of this practice, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. In addition, I authorize release of my medical information as necessary to other health care providers, including physicians, pharmacies and physical/occupational therapists.

Signed: _____ Date: _____