

Miami Joint Restoration Center  
Jeffrey A. Rich, D.O., P.A.

**Please Print Clearly**

e-mail address: \_\_\_\_\_

Name: _____			Age: _____
Last Name	First Name	MI	
Adress: _____			Date of Birth: _____
City/State : _____		Zip: _____	Home Phone: _____
Marital Status :      Single      Divorced (please circle)      Married      Widowed			Cell Phone: _____
Social Security #: _____			Male or Female (please circle)
Name of Primary Care Physician : _____			Phone #: _____
Name of Referring Physician: _____			Phone #: _____

Emergency Contact: _____	Contacts's Phone: _____
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**Minor Information**

Guardian/ Custodial Parent Name: _____	
Social Security #: _____ - _____ - _____	Work Phone: (    ) _____
Home Phone: (    ) _____	Cell Phone: (    ) _____

**Patient Employer/School Information**

Occupation: _____	Patient Employer/School Name: _____
Phone # : _____	

Is this condition related to an Auto Accident ? Yes No (please circle) Date of Accident _____
Is this condition related to a Job Injury ? Yes No (please circle) Date of Accident _____

Primary Insurance: _____ Adress: _____ Policy # : _____ Group# : _____ Phone: (    ) _____ Who is the Insured?: _____	Secondary Insurance: _____ Address: _____ Policy # : _____ Group#: _____ Phone: (    ) _____ Who is the Insured?: _____
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**Insurance Assignment Release**

I hereby authorize payment directly to Jeffrey A. Rich, D.O. PA of benefits due from my insurance company otherwise payable to me.

I further authorize release of any medical information required by my insurance carrier(S).

I authorize any holder of medical or other information about me to be released to the Social Security Administration and health care financial administration or its intermediaries or carriers, any information needed for this or a related Medicare claim.

I understand I am financially responsible for any portion not covered by my insurance company.

**There is a \$25.00 charge for no show appointments, please cancel appointments 24 hours in advance.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_