ocpn | easton
ORTHOPEDIC CARE PHYSICIAN NETWORK
& REHABILITATION SERVICES

15 Roche Bros. Way
Suite 200
North Easton, MA 02356
Tel: 781-344-3535
Fax: 781-341-2404

ACCT. #: _____

ACQUAINTANCE SLIP

(PLEASE PRINT)

PATIENT

PATIENT'S NAME _____ DATE OF BIRTH _____
(FIRST) (MIDDLE) (LAST)

☐ MALE ☐ FEMALE PT'S. SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____
(AREA CODE) (AREA CODE)

E-MAIL ADDRESS: _____

EMERG. CONTACT NAME _____ EMERG. CONTACT PHONE _____
(AREA CODE)

☐ SINGLE ☐ MARRIED ☐ DEPENDENT CHILD ☐ WIDOWED ☐ DIVORCED

EMPLOYER _____ PHONE _____
(AREA CODE)

EMPLOYER'S ADDRESS _____

PRIMARY CARE PHYSICIAN _____

NAME OF SPOUSE _____

GUARDIAN

NAME OF PARENT/GUARDIAN _____

D.O.B. OF PARENT/GUARDIAN _____

ADDRESS IF DIFFERENT FROM PATIENT'S _____

INSURANCE

PRIMARY INSURANCE ID # _____
(circle one) BCBS Medicare Masshealth Tufts Harvard Pilgrim Cigna Aetna UHC NHP BMC
OTHER _____
NAME OF CARDHOLDER _____ CARDHOLDER'S DOB _____
ADDRESS IF DIFFERENT FROM PATIENT'S _____

2ND INSURANCE ID # _____
(circle one) BCBS Medicare Masshealth Tufts Harvard Pilgrim Cigna Aetna UHC NHP BMC
OTHER _____
NAME OF CARDHOLDER _____ CARDHOLDER'S DOB _____
ADDRESS IF DIFFERENT FROM PATIENT'S _____

3RD INSURANCE ID # _____
(circle one) BCBS Medicare Masshealth Tufts Harvard Pilgrim Cigna Aetna UHC NHP BMC
OTHER _____
NAME OF CARDHOLDER _____ CARDHOLDER'S DOB _____
ADDRESS IF DIFFERENT FROM PATIENT'S _____

IS THIS A WORKMAN'S COMP INJURY? ☐ YES ☐ NO DATE OF INJURY _____
IS THIS AN AUTO RELATED INJURY? ☐ YES ☐ NO DATE OF INJURY _____

I authorize my insurance company to pay medical benefits directly to ORTHOPEDIC CARE PHYSICIAN NETWORK & REHABILITATION SERVICES. I further authorize ORTHOPEDIC CARE PHYSICIAN NETWORK & REHABILITATION SERVICES to give my insurance company all the information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis.

I acknowledge receipt of Orthopedic Care Physician Network & Rehabilitation Services' privacy policies

Signed _____ **Date** _____

HEALTHCARE REFORM
Demographic Data Collection

LANGUAGE: (CHECK ONE)

- ☐ English
- ☐ Portuguese or Portuguese Creole
- ☐ Arabic
- ☐ Chinese
- ☐ French (include: Patois, Cajun)
- ☐ French Creole
- ☐ German
- ☐ Italian
- ☐ Mon-Khmer, Cambodian
- ☐ Spanish or Spanish Creole
- ☐ Vietnamese
- ☐ Russian
- ☐ Greek
- ☐ Polish
- ☐ Declines to answer

RACE: (CHECK ONE)

- ☐ Black or African American
- ☐ Asian
- ☐ Caucasian / White
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ American Indian or Alaska Native
- ☐ State Prohibited
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Multiracial
- ☐ Patient Declined to Answer
- ☐ Other
- ☐ Undetermined

ETHNICITY: (CHECK ONE)

- ☐ Hispanic or Latino
- ☐ Patient Declined
- ☐ State Prohibited
- ☐ Not Hispanic or Latino
- ☐ Other or Undetermined