ocpn | raynham
ORTHOPEDIC CARE PHYSICIAN NETWORK
& REHABILITATION SERVICES

675 Paramount Drive
Suite 205
Raynham, MA 02767
Tel: 508-828-5848
Fax: 508-828-5846

ACCT. #: ______________________

ACQUAINTANCE SLIP

(PLEASE PRINT)

PATIENT

PATIENT'S NAME ______________________ (FIRST / MIDDLE / LAST) DATE OF BIRTH ____________

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

ADDRESS ____________ CITY ____________ STATE _____ ZIP ____________

HOME PHONE ____________ (AREA CODE) CELL PHONE ____________ (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