Casscells
Orthopaedics & Sports Medicine

Patient Information

2600 Glasgow Ave., Suite 104,Newark, DE 19702
P :(302) 832-6220 F :(302) 832-6226

Please fill out in blue or black ink

Name: _____ SS#: _____

D.O.B.: _____ Marital Status: _____ Sex: ☐ M ■ F Student Status: ○ Full ◉ Part ○ None *(Circle One)*

Race: _____ Language: _____ Ethnicity *(Circle One)*: Hispanic/Latino Non-Hispanic/Latino

Address: _____

City, State & Zip: _____

Home Phone: _____ Alt Phone: _____

Primary Care Physician: _____ Referred By: _____

Primary Employer: _____ Full-Time / Part-Time *(Circle One)* Work Phone: _____

Address: _____

City, State & Zip: _____

Emergency Contact/Relationship: _____ Phone#: _____

Responsible Party Information *(If Different Than Above)*

Name: _____ SS#: _____ D.O.B: _____

Address: _____

City, State & Zip: _____

Home Phone: _____ Relationship to Patient: _____

Circle One: Primary Insurance Workers Comp Auto Accident

PLEASE FILL ALL INFORMATION OUT

Insurance Company: _____ Policy/Claim#: _____ Group/Acct#: _____

Subscriber/Adjuster's Name: _____ Phone#: _____ D.O.B. /D.O.I.: _____

Relationship to Insured: _____ State of Accident *(Auto Only)*: _____

Secondary Insurance PLEASE FILL OUT ALL INFORMATION IF APPLICABLE

Insurance Company _____ Policy#: _____ Group/Acct#: _____

Subscriber's Name _____ D.O.B: _____ Relationship: _____

Tertiary Insurance PLEASE FILL OUT ALL INFORMATION IF APPLICABLE

Insurance Company: _____ Policy#: _____ Group/Acct#: _____

Subscriber's Name: _____ D.O.B: _____ Relationship: _____

Please let us know how you would like to be reminded of upcoming appointments.

You will be contacted 48 hours prior to your appointment with Dr. Casscells. Please list below how you would like to be reminded of future appointments. Please list the most convenient option for you, and be sure to update us if this information should change.

Phone: _____ E-mail: _____

I hereby authorize Casscells Orthopaedics and Sports Medicine, PA to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance. Once an amount is assigned as a patient balance, I will have 30 days to pay the amount before a 5% late fee will be assessed. If the patient is under 18 years of age, guarantor must sign.

_____ _____

Signature of Patient/Guardian Date