John C. Kefalas, M.D., FAAOS
Board Certified in Orthopedic Surgery

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Last Name	First Name	MI		Sex ☐ Male ☐ Female
Birth Date	Age	Soc. Sec. No.		Driver's License No.
Home Address	City	State	Zip	Best Phone number
Primary Care Physician			How did you hear about our practice?	
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other			Emergency contact name and phone number	
Is your current condition work-related and authorized as a worker's compensation care? ☐ Yes ☐ No				
Is your current condition due to a motor vehicle accident? ☐ Yes ☐ No				
Is your current condition due to any other accident? ☐ Yes ☐ No				
Patient Employer Information				
Employer's Name			Employer's Phone No.	
Employer's Address	City	State	Zip	
Billing information (please fill out if patient is a minor)				
Last Name	First Name	MI		
Birth Date	Age	Soc. Sec. No		Sex ☐ Male ☐ Female
Employer's Name			Employer's Phone No.	
Employer's Address	City	State	Zip	
Primary Insurance (please skip if a copy of insurance card has been provided)				
Primary Insurance Company			Policy holder name	
Birth Date	Age	Soc. Sec. No.		Sex ☐ Male ☐ Female
Address	City	State	Zip	
Insurance ID No.	Group No.		Insurance phone No.	
Secondary Insurance (please skip if a copy of insurance card has been provided)				
Secondary Insurance Company			Policy holder name	
Birth Date Female	Age	Soc. Sec. No		Sex ☐ Male ☐
Address	City	State	Zip	
Insurance ID No.	Group No.		Insurance phone No.	

I hereby authorize this provider to release to any party responsible for payment, any information acquired in the course of medical examinations or treatment. I request that payment of authorized Medicare/Insurance benefits be made on my behalf to the party who accepts assignment for any services furnished to me by the supplier. I authorize this provider to release medical information about me to the Center of Medicare and Medicaid Services and/or my insurance company and its agents that is needed to determine these benefits or the benefits payable to related services.

I hereby authorize the provider to receive direct payment for the amount due to me in my pending claim for services rendered. I understand that I am financially responsible for charges not covered by my insurance and/or authorization. A photocopy of this authorization shall be considered as effect and valid as the original.

Signature: _____ **Date:** _____