John C. Kefalas, M.D., S.C.
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	Home Phone	Work Phone
Primary Care Physician	How did you hear about our practice?				
Emergency Phone	Emergency Contact	Marital Status ☐Single ☐Married ☐Widow ☐Other			
Is condition work-related and authorized as a worker's Compensation Care? ☐Yes ☐No					
Is this condition due to a motor vehicle accident? ☐Yes ☐No					
Is this condition due to any other accident? ☐Yes ☐No					
Patient Employer Information					
Employer's Name	Employer's Phone				
Employer's Address	City	State	Zip		
Billing Information					
Last Name	First Name	MI			
Birth Date	Age	Soc. Sec. No.	Sex ☐Male ☐ Female		
Employer's Name	Employer's Phone				
Employer's Address	City	State	Zip		
Primary Insurance (Please skip if a copy of insurance cards have been provided)					
Primary Insurance Company	Policy Holder Name				
Birth Date	Age	Soc. Sec. No.			
Address	City	State	Zip		
Insurance ID No.	Group No.	Insurance Phone			
Secondary Insurance (Please skip if a copy of insurance cards have been provided)					
Secondary Insurance Company	Policy Holder Name				
Birth Date	Age	Soc. Sec. No.			
Address	City	State	Zip		
Insurance ID No.	Group No.	Insurance Phone			

I hereby authorize the physician 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 benefits be made on my behalf to the party who accept assignment for any services furnished to me by the supplier. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize the physician to receive direct payment for the amount due to me in my pending claim for physician's services rendered. I understand that I am financially responsible for charges not covered by this authorization. A Photostat of the authorization shall be considered as effective and valid as the original.

_____ _____

Signature **Date**