

**WAYNE MEMORIAL HOSPITAL**  
*Honesdale Orthopaedic Surgery*  
David Caucci, M.D     Keith M. Cordischi D.O.

DATE \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ PRIOR LAST NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ ALTERNATE PHONE: \_\_\_\_\_

CONTACT BY: (Circle One) Home Phone Cell Phone Email SEX: M F SOCIAL SECURITY # \_\_\_\_\_

PERSON TO NOTIFY IN CASE OF EMERGENCY \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER & EMPLOYER TELEPHONE #: \_\_\_\_\_

HOW WERE YOU REFERRED TO OUR OFFICE: \_\_\_\_\_

IF MINOR CHILD - NAME OF PARENT OR GUARDIAN: \_\_\_\_\_

\* GUARANTOR IS THE PERSON FINANCIALLY RESPONSIBLE FOR BALANCES. IF OTHER THAN THE PATIENT PLEASE PROVIDE REQUIRED INFORMATION- GUARANTOR IS: PATIENT OTHER \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ TELEPHONE # OF GUARANTOR: \_\_\_\_\_

***INSURANCE INFORMATION-PLEASE PROVIDE CARD***  
PATIENT WILL BE CONSIDERED A SELF-PAY ACCOUNT UNTIL INFORMATION IS PROVIDED

PRIMARY INSURANCE: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_

PRIMARY INSURANCE HOLDER INFORMATION: INSURED IS: PATIENT OTHER

INSURANCE ID# \_\_\_\_\_

GROUP ID# \_\_\_\_\_

NAME OF INSURED (POLICY HOLDER): \_\_\_\_\_

POLICYHOLDER DATE OF BIRTH: \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS OF INSURED: \_\_\_\_\_

TELEPHONE NUMBER OF INSURED: \_\_\_\_\_

SOCIAL SECURITY NUMBER OF INSURED: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

SECONDARY INSURANCE HOLDER INFORMATION: INSURED IS: PATIENT OTHER

INSURANCE ID# \_\_\_\_\_

GROUP ID# \_\_\_\_\_

NAME OF INSURED (POLICY HOLDER) : \_\_\_\_\_

POLICYHOLDER DATE OF BIRTH: \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS OF INSURED: \_\_\_\_\_

TELEPHONE NUMBER OF INSURED: \_\_\_\_\_

SOCIAL SECURITY NUMBER OF INSURED: \_\_\_\_\_

PHARMACY PREFERENCE \_\_\_\_\_ CITY/STATE \_\_\_\_\_

I undersigned, hereby CONSENT TO TREATMENT and grant permission to release my medical information and to authorize payment of health insurance benefits to the above-named doctor(s). I also understand that I am fully responsible for payment of deductibles and co-insurance and any charges that are incurred and not covered by my health insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PAYMENT: We accept cash, checks and credit cards. Payment is due upon receipt of medical services. Co-payments must be paid at the time of your visit. If financial arrangements are needed, please notify the receptionist, as approval will be needed before your visit.