STEVEN E. GOODWILLER, M.D., P.A.
DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY

PATIENT INFORMATION

Name: _____ Referring Physician: _____
_ Male _ Female Date of Birth: _____ Date of Injury : _____
Social Security #: _____ Chief Complaint _____
Marital Status: _ Single _ Married _ Divorced _ Other
Address: _____
_____
City_____ State____ Zip: _____
Home Phone: _(_____)_____
Cell Phone: _(_____)_____
Work Phone: _(_____)_____Employer _____
Emergency Contact: _____Phone: _____
Race: _ Caucasian _ Hispanic _ African-American _ Other
Ethnicity: _ Hispanic _ Non-Hispanic _ Unknown

PRIMARY INSURANCE
Policy Holder: _ Patient _ Guarantor _ Spouse _ Other
Insurance Company:
_____
Policy #: _____
Policy Holder:
_____
Relationship to Patient: _ Spouse _ Child _ Other
Insured Date of Birth:
_____
Insured SS #: _____
Group #: _____

SECONDARY INSURANCE
Policy Holder: _ Patient _ Guarantor _ Spouse _ Other
Insurance Company:
_____
Policy #: _____
Policy Holder:
_____
Relationship to Patient: _ Spouse _ Child _ Other
Insured Date of Birth:
_____
Insured SS #: _____
Group #: _____

MEDICARE PART B SIGNATURE AUTHORIZATION- LIFETIME

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, or to the billing agent of Steven E. Goodwiller, M.D. any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. This is for Medicare patients only. If not a Medicare patient this does not apply to your visit.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby consent to the release of all information concerning my treatment to (Please list any family member, other physician, etc. We may discuss and/or release your medical information to.)

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I release Dr. Goodwiller from all legal responsibility or possible liability that may arise from this consent.

Signature X_____ Witness Signature_____ Date_____

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