

Meeks & Zilberfarb Orthopedics

1101 Beacon Street, 5th floor

Brookline, MA 02446

Tel. (617) 232-6342

Patient Information

Last Name:

First Name:

MI:

Home Address:

Home Phone:

Work Phone:

Cell Phone:

Date of Birth:

Sex:

Marital Status:

Social Security Number:

Email Address:

Employer:

Primary Care Physician:

Referred By: _____

Primary Language: _____

Race: *Please select one*

American Indian or Alaska Native

White

Asian

Black or African American

Hispanic

Native Hawaiian

Other Race: _____

Refuse to Report

Ethnicity: *Please select one*

Hispanic

Non-Hispanic

Refuse to Report

Insurance Information

Secondary Information

Insurance Name:

Insurance Name:

Subscriber Number:

Subscriber Number:

Group Number:

Group Number:

Insurance Address:

Insurance Address:

Subscriber:

Subscriber:

Subscriber's Name:

Subscriber's Name:

Subscriber's Social Security Number:

Subscriber's Social Security Number:

Medical Information

Allergies: _____

Pharmacy: _____ **Phone:** _____ **Fax:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Who is financially responsible for this bill? _____

Authorization

I authorize the release of medical information necessary to process medical benefits and I authorize payment of medical benefits to Meeks & Zilberfarb Orthopedics for services by their office.

Signed _____

Date: _____

Please note, Meeks & Zilberfarb Orthopedics cannot refill any medications after business hours or on weekends.

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Patient name: _____

HIPAA Notice of Patient Privacy Practices

I acknowledge receipt of Meeks & Zilberfarb Orthopedics practice privacy notice. I may request an additional copy of the privacy notice at any time.

Signed _____ Date: _____

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers:

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Signed _____ Date: _____

Consent for RX Hub Inquiry

I hereby provide my consent for Meeks & Zilberfarb Orthopedics to obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Signed _____ Date: _____