



Leonard Karadimas, D.O.  
Timothy Lukas, M.D.

Knee & Shoulder Specialists

Board Certified Orthopedic Surgeons  
Sports Medicine Specialists

**Patient Information**

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (If Different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Race \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School Name \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Primary Care Physicians Name \_\_\_\_\_

Would you like your records sent to your physician? Yes \_\_\_\_\_ No \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Whom may we talk to about your care? \_\_\_\_\_

**Insurance**

**Was this injury sustained on the job? Yes \_\_\_\_\_ No \_\_\_\_\_ Was a claim filed? Yes \_\_\_\_\_ No \_\_\_\_\_**

Primary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Subscriber Address (If different from patient) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Subscriber Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Subscriber Address (If different from patient) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Subscriber Employer \_\_\_\_\_

See reverse side...

**Guarantor** (If patient is a minor)

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_

**Consent For Treatment:** I hereby consent to necessary examination, procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

**Financial Responsibility:** I acknowledge full financial responsibility for services rendered. I also understand that payment of charges incurred is due at time of services.

**Authorization To Release Information:** I hereby understand and acknowledge I have been provided with a *Notice of Privacy Practices*. I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.

**Assignment Of Benefits:** I hereby authorize my insurance benefits to be paid directly to *Advanced Orthopedics*. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature (Parent or Guardian if child is a minor) \_\_\_\_\_

Date \_\_\_\_\_