# Winthrop Orthopaedic Associates, PC

Main Office: 1300 Franklin Avenue, Garden City NY 11530 ● Tel: (516) 747-8900 ● Fax: (516) 663-3015
Satellite Office: 2339 Hempstead Turnpike, East Meadow, N.Y. 11554 ● Tel: (516) 520-3164 ● Fax: (516) 520-5713
www.winthroporthopaedics.com

## Patient Insurance Information Form

*(Must be filled out completely by all patients)*

**Primary Insurance:** ________________________________________

Policy ID#: ________________________________________

Group #: ________________________________________

Effective Date: ____________________________ Expiration Date: ________________________

Policy Holder: ____________________________ Policy Holder's DOB: _________________

Policy Holder's SS#: _________________________ Policy Holder's Sex: M F

Policy Holder's Address: ___________________________________________________________________

Relationship to Patient: Self Spouse Parent Guardian

**Secondary Insurance:** ________________________________________

Policy ID#: ________________________________________

Group #: ________________________________________

Effective Date: ____________________________ Expiration Date: ________________________

Policy Holder: ____________________________ Policy Holder's DOB: _________________

Policy Holder's SS#: _________________________ Policy Holder's Sex: M F

Policy Holder's Address: ___________________________________________________________________

Relationship to Patient: Self Spouse Parent Guardian

**IF CLAIM IS NO FAULT OR WORKERS COMPENSATION PLEASE NOTIFY THE RECEPTIONIST FOR THE APPROPRIATE FORMS… THIS IS YOUR RESPONSIBILITY!**

Did injury occur at school? ______________________________________________________________
School Name: ______________________________________________________________
School Phone#: ______________________________________________________________
School Insurance Carrier Name: ______________________________________________________________
School Insurance Address: ______________________________________________________________
City, State & Zip: ______________________________________________________________
Date of Injury: ______________________________________________________________
If injury occurred during a school sport, please give name of sport: _______________________________