EVANGELISTA ORTHOPEDIC CLINIC

Gregory T. Evangelista, M.D.
Amanda Damiris, PA-C

Patient Information

Name : Last, First, MI _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Social Security _____

What is your occupation? _____ Employer _____

Primary Care Doctor _____ PCP Phone #: _____

Referred By _____ If Dr. referred, Phone #: _____

Date of Birth ____ / ____ / _____ Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W

Email _____ OK to leave message at home? ☐ Yes ☐ No

Emergency Contact _____ Relation _____ Phone _____

Race _____ Ethnicity _____ Primary Language _____

Pharmacy _____ Cross streets _____ Phone _____

Do you authorize eoclinic to share medication history with the pharmacy listed above? ☐ Yes ☐ No

Primary Insurance Company _____

Policy Holder _____ Date of Birth ____ / ____ / _____

ID/Policy # _____ Group # _____ Co-Pay _____

Secondary Insurance Company _____

Policy Holder _____ Date of Birth ____ / ____ / _____

ID/Policy # _____ Group # _____ Co-Pay _____

Work Related? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Attorney Involved ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Evangelista Orthopedic Clinic for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim**. I understand that I am responsible for all charges not covered by my insurance**. I authorize the release of any medical or other information necessary to process my medical claims. In addition, I authorize the release of medical information to my primary care or referring physician(s) in regard to my management.

Signature _____ Date _____