WC/NO FAULT **PETER A. MATSUURA, M.D. Orthopaedic Surgery & Sports Medicine**

Patient's Name: _____DOB: _____ Age: _____ Sex: ___SS#:_____

Street Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Email Address: _____

Employer's Name: _____ Occupation: _____

Race: ☐ American Indian/Native Alaskan ☐ Asian ☐ African or Black ☐ Native Hawaiian/Pacific Islander ☐ White

Language: ☐ English ☐ Other _____ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

☐ Check box if you **do not** authorize us to leave a voice message for you on any of your telephone lines

Release of Protected Health Information: ☐ **Yes** ☐ **No** You may release my Protected Health Information (medical records) to my primary care provider, spouse, family member, significant other, or caregivers requesting them on my behalf:

Name(s): _____

Emergency Notification: Name: _____ Phone: _____Relationship: _____

Referral: Who referred you to Dr. Peter Matsuura? _____

Primary Physician Name: _____ Phone: _____

Insurance Carrier:

Name of Insurance Company: _____

Adjuster's Name: _____Phone #: (_____)_____

Claim Number**:** _____

Injury Description:

1. **Date of Injury or onset of problem:** _____/_____/_____
2. **Identify the injured area (i.e. right elbow, etc.):**_____
3. **Briefly describe how you got hurt:** _____

Agreement: *As the responsible party,*

☐ *I authorize payment of insurance payments to Peter A. Matsuura, M.D.*

☐ *I have read, understand and agree to Dr. Peter Matsuura's Patient Payment Policy. I understand that charges not covered by my insurance company are my responsibility and will pay for my portion directly to Peter A. Matsuura, M.D. at the time of service.*

☐ *I have received for review Dr. Matsuura's Notice of Privacy Practices for Protected Health Information.*

Signed: _____ Date: _____