Genesee Orthopaedics and Sports Medicine, LLP
Matthew J. Landfried, MD
Richard K. Hoy, MD
Joseph V. Otten, MD
33 Chandler Ave
Batavia, NY 14020

Dear Patient,

If you are a new patient with an appointment at our office, you may download the necessary forms instead of having them mailed to you at home. In order to help with your appointment, it is best to complete the forms and mail back to our Batavia office so that we may get your information into our computer prior to your visit. The Patient Information, Medical History and Drug Policy Forms must be completed, signed and returned to the office prior to your being seen by the doctor. The HIPAA Privacy Notice will be signed electronically in the office at your first visit.

Bring your insurance card to the appointment so that we can scan it into your chart.
Co-payments are required to be paid upon check-in the day of your appointment or your appointment will be rescheduled. Some insurance companies require a second co-pay when an x-ray or an injection is done.

If you are filing under Workers' Compensation or Motor Vehicle/No Fault, you must bring complete billing information to your first appointment. We will need the Insurance Carrier's name, address, phone number and fax number as well as a claim number in order to properly care for you. For your convenience, there are forms for Workers' Compensation and Motor Vehicle/No Fault that you can download, print and complete for your visit.

If you have had x-rays done, please bring them to your appointment. You must give at least 48 hour notice to the x-ray facility/hospital in order to pick up films. If you have had your films done at United Memorial Medical Center in Batavia (either location) or Pembroke - you do not need to pick up films or disks. We can access your films at the hospital in our office. Here are some of the local facility numbers for your convenience: WCCH 786-2233; LeRoy 768-4220; Advanced Imaging 345-9729; Medina Memorial 798-2000.

Thank you,
Genesee Orthopaedics Staff

For more information regarding your concerns, we encourage you to visit the American Academy of Orthopaedic Surgeons website. Please bring any questions with you to your appointment.

www.orthoinfo.aaos.org

GENESEE ORTHOPAEDICS AND SPORTS MEDICINE, LLP
PATIENT INFORMATION FORM

PLEASE COMPLETE ALL INFORMATION (please print):

APPOINTMENT DATE: ___________________________

Name of Patient: ____ Gender: Male / Female

Address:____

City_________________________________ State________ Zip Code____________________

Home Phone:_________________Work #:____________________ Cell #:_________________

Pharmacy Name:____

Mail Order Pharmacy:____

Patient's DOB: _______________ Patient's Social Security #: _________________________

Referring Doctor: ____

Family Doctor/PCP: ____

Address:____

City_________________________________ State________ Zip Code____________________

Phone: ______________________________

HIPAA Privacy Questions regarding appointment and medical information:

Is it okay to leave a message on your answering machine?	Yes / No	Not applicable
Is it okay to leave a message on your office voice mail?	Yes / No	Not applicable
Is it okay to leave a message with another person?	Yes / No	Not applicable
Is it okay to send you mail?	Yes / No	
Is it okay to call your cell phone?	Yes / No	Not applicable

Tell us who it is okay to speak with in regards to your medical care:

____

In case of an emergency, who should we contact (include name and phone #):

____

INSURANCE INFORMATION:

Are you filing under Workers' Compensation? Yes / No
Are you filing under Motor Vehicle/NoFault? Yes / No

Name of Health Insurance Company____

Cardholder's Name_____________________________________

Policy/ID # & Suffix #____________________________________

Cardholder's DOB_________________ Cardholder's SS#________________________

Group #_________________ Copay for Specialist____________(REQUIRED AT THE TIME OF VISIT OR YOUR APPOINTMENT WILL BE RESCHEDULED. SOME INSURANCES REQUIRE A SECOND COPAY WHEN AN XRAY OR INJECTION IS DONE.)

Cardholder's Employer's Name____

Employer's Address:____

City_________________________________ State________ Zip Code_____________

Do you have a secondary insurance plan? Yes/No

Name of Secondary Insurance company_______________________________________

Cardholder's Name______________________________________

Policy/ID # & Suffix #____________________________________

Do you have a prescription insurance plan? Yes/No

Have you had recent x-rays of this injury or problem? Yes / No

(If you have had recent x-rays - please bring to your appointment.)

Patient Signature____

Date____________________________