NORTH SHORE SHOULDER, LLC
Robert E. McLaughlin II, MD

Please complete and return to the receptionist.

Patient Information

Name: _____ Date of Birth: _____

Address: _____ City:_____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____Work Phone:_____

Email address:_____

Marital Status: ____Male/Female:_____ Social Security Number: _____

Primary Care Physician: _____

Insurance Information

Insurance Name: _____Policy #:_____Grp#:_____

Subscriber: _____ Date of Birth of Subscriber: _____ Telephone: _____

Address (if different than above): _____

Secondary Insurance: _____

Is referral necessary for your insurance? _____ If yes, was PCP notified of visit? _____

Is this a work related accident? _____ If yes, employer name: _____

WC Insurance Carrier: _____ Claim Number: _____

Is this related to a motor vehicle accident? _____

If yes, MVA InsuranceCarrier: _____ Claim Number: _____

Emergency Contact

Name_____ Relation: _____

Telephone Number: Cell: _____ Home: _____

Pharmacy Name: _____Pharmacy Address: _____

ALL COPAYS ARE DUE AT THE TIME OF SERVICE 4/2010