

Richard R. Renaud, M.D.  
Orthopaedic Surgery / Sports Medicine

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**PATIENT INFORMATION**

PATIENT NAME \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ GENDER M F  
ADDRESS \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_  
CITY \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PRIMARY DOCTOR \_\_\_\_\_  
EMERGENCY PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
DATE OF INJURY \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**IF PATIENT IS A CHILD OR DEPENDENT, PLEASE COMPLETE THIS BOX WITH NAME & ADDRESS OF PARENT OR GUARDIAN**

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**INSURANCE INFORMATION**

COMPANY \_\_\_\_\_ POLICY# \_\_\_\_\_

**PLEASE READ THE STATEMENT BELOW AND SIGN WHERE INDICATED:**

I hereby authorize Richard R. Renaud, M.D. to provide the medical treatment necessary to furnish quality healthcare to me. I also authorize him to exchange protected health information with other physicians and healthcare providers that are involved in my care. I authorize the release of any protected health information necessary to process my claims. I also authorize payment of medical benefits to my physician for services rendered. I further authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers of insurance companies, any information needed for this or a related Medicare or insurance claim. I also understand that I am financially responsible for those charges not covered by this authorization. I permit a copy of this authorization to be used in place of the original.

**SIGN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_