

ORTHOPAEDIC ASSOCIATES, INC. PATIENT REGISTRATION

PATIENT REGISTRATION

Have you been a patient before: \_\_\_\_\_ Referring Physician \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ SS# \_\_\_\_\_

Date of Injury \_\_\_\_\_ Have contacted an attorney about this injury? \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Street / City \_\_\_\_\_

RESPONSIBLE PARTY

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

PRIMARY INSURANCE

Name of Insurance Co. \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

SECONDARY INSURANCE

Name of Insurance Co. \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

WORKER'S COMPENSATION INFORMATION (IF APPLICABLE)

Was an accident report filed? \_\_\_\_\_ Claim # \_\_\_\_\_ Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_

Work Related Insurance Co. (MCO or self-insured) \_\_\_\_\_

Employer (at time of injury) \_\_\_\_\_ Employer Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION** I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to Orthopaedic Associates, Inc. This assignment will remain in effect until revoked by me in writing. I hereby authorize Orthopaedic Associates, Inc. to release any/all information necessary to secure payment of said benefits. I understand that I am financially responsible for all charges/services whether or not paid by said insurance, including Worker's Compensation claims. Charges may include all medical, surgical, physical and occupational therapy services.

Signature \_\_\_\_\_

Date \_\_\_\_\_