

# PATIENT REGISTRATION

**Referring Physician:** \_\_\_\_\_

Referring MD Phone #: \_\_\_\_\_

**PATIENT NUMBER:** \_\_\_\_\_

Primary Physician Name #: \_\_\_\_\_

Primary Physician Phone #: \_\_\_\_\_

**NAME** (Last, First, MI) \_\_\_\_\_ **SEX** M F

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mail Address (If Different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Spouse/Parent/Guardian Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Parents Employer: Mother: \_\_\_\_\_ Phone #: \_\_\_\_\_

Father: \_\_\_\_\_ Phone #: \_\_\_\_\_

Allergies: \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT:** NAME: \_\_\_\_\_ Phone #: \_\_\_\_\_

## PRIMARY INSURANCE

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT:** Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

## OTHER INSURANCE

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insured Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_

**FOR MEDICARE PATIENTS: IS THIS A MEDIGAP?** YES: \_\_\_\_\_ NO: \_\_\_\_\_

\_\_\_\_\_  
WAS THIS INJURY RELATED TO EMPLOYMENT, A MOTOR VEHICLE ACCIDENT, SCHOOL INJURY (OR OTHER LIABILITY) \_\_\_\_\_

\_\_\_\_\_  
WHERE DID INJURY OCCUR? DESCRIBE CIRCUMSTANCES OF INJURY: (DATE, LOCATION, HOW DID IT HAPPEN?) \_\_\_\_\_

\_\_\_\_\_  
ARE YOU PURSUING LEGAL ACTION? \_\_\_\_\_

**Assignment of Benefits:** I irrevocably assign/authorize to Orthopedic Associates of L.I., LLP the following: a: all of my rights and benefits under Medicare or any insurance contracts for payment of services rendered to me by him, b: all information regarding my benefits under any insurance policy relating to his claims to be released to him, c: to file insurance claims on my behalf including Medigap, if applicable for services rendered to me, d: direct that all such payments go directly to him, e: to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities, f: I authorize the provider to release any information necessary to substantiate a claim. In the event my account goes to collection, I understand that I will be responsible for all collection fees including costs of an attorney. Any questions I may have concerning this assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

\_\_\_\_\_  
PATIENTS SIGNATURE (If minor, parent or guardian)

\_\_\_\_\_  
DATE

Checked By: \_\_\_\_\_ Date: \_\_\_\_\_