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:_____