

PATIENT REGISTRATION



Patient Name _____ last _____ first _____ middle initial _____ Male
Female

Mailing Address _____ street _____ apt. # _____ Home Phone _____
_____ city _____ state _____ zip _____ Day/Cell Phone _____ E-mail _____

Marital Status: Single Married Separated Widow/er Dependent Domestic Partner

Birthdate ____/____/____ Age _____ Social Security# _____

Primary Care Physician _____

Referred by Dr. _____ last _____ first _____ Phone _____

Referred by Patient/Other _____ last _____ first _____ Phone _____

Patient's Employer/School _____ Phone _____

Parents/Spouse/Domestic Partner Name _____ Employer _____ Phone _____

PRIMARY INSURANCE

ANY OTHER INSURANCE

Ins. Co. Name _____

Ins. Co. Name _____

Subscriber Name _____

Subscriber Name _____

Birthdate ____/____/____

Birthdate ____/____/____

Group # _____ ID # _____

Group # _____ ID # _____

Subscriber's Employer _____

Subscriber's Employer _____

Does your insurance carrier require a referral? Yes () No ()

BILLING INFORMATION

(Complete if person responsible for bill is not the patient.)

Name of Person Responsible for Bill _____ relationship _____ social security # _____

Address (if not as above) _____ street _____ city _____ state _____ zip _____

Home Phone _____ Employer _____

Work Phone _____ Address _____

INFORMATION ABOUT YOUR CONDITION

What part of the body are you being seen for today? _____ L R

Is this result of an injury? Yes No If **yes**, please complete the following: Date of Injury ____/____/____ Claim Number: _____

Workers Compensation Billing Address: _____ street _____ city _____ state _____ zip _____

Claim Manager Name: _____ Phone: _____

I authorize my insurance benefits to be paid to Orthopedic Physician Associates. I understand I am financially responsible for any balance that my insurance does not pay. I authorize the doctor or insurance company to release any information required for this claim.

_____ signature _____ date