

PATIENT REGISTRATION

Male ()
Female ()

Patient Name _____ last _____ first _____ middle initial _____

Mailing Address _____ street _____ apt. # _____ Home Phone (_____) _____
_____ city _____ state _____ zip _____ Day/Cell Phone _____

Marital Status: Single () Married () Separated () Divorced () Widow/er () Dependent ()

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 _____

Parent/Spouse Name _____ Employer _____ Phone _____

IN ORDER TO BILL YOUR INSURANCE, WE MUST HAVE A COPY OF YOUR CARD PRIMARY INSURANCE ANY OTHER INSURANCE

Ins. Co. Name _____	Ins. Co. Name _____
Subscriber Name _____	Subscriber Name _____
Date of Birth _____	Date of Birth _____
Group # _____ ID # _____	Group # _____ ID # _____
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 the result of an injury? Yes _____ No _____ If yes please complete the following:

Date of Injury _____ How did the injury happen? _____

Workers compensation claim number: _____

Workers compensation billing address: _____ street _____ city _____ state _____ zip _____

Claim Manager Name: _____ Phone: _____

Name of local person not living with you _____ Relationship _____

Address _____ Telephone # _____

I authorize my insurance benefits to be paid directly 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