PATIENT REGISTRATION (Please Print)

ACCOUNT NUMBER____________________

FAMILY PHYSICIAN and. or
REFERRED TO THIS OFFICE BY:____________________

PATIENT'S NAME____________________ DATE OF BIRTH________ AGE____
Last First Middle

HOME ADDRESS____________________
Street City State Zip County

SEX____ SOCIAL SECURITY NUMBER______ ____ ______ **M**ARITAL STATUS: ( )**S**INGLE ( )**M**ARRIED ( )**D**IVORCED ( ) **X**-SEPARATED ( )**W**IDOWED

LANGUAGE__________ RACE__________ ETHNICITY__________ UNKNOWN ( )

PATIENT EMPLOYMENT STATUS: (Circle One) **F**-Full Time Student **P**-Part Time Student **1**-Employed Full Time **2**-Employed Part Time **3**-Not Employed **4**-Self Employed **5**-Retired **6**-Active Military

PATIENT'S EMPLOYER and EMPLOYER ADDRESS ____________________

HOME PHONE__________ WORK PHONE__________ SPOUSES NAME __________

EMAIL____________________

RESPONSIBLE PERSON:____________________ RELATIONSHIP: __________

ADDRESS: ____________________

EMPLOYER:____________________ RESPONSIBLE PARTY PHONE: __________

EMPLOYER ADDRESS & PHONE: ____________________

COMPLAINT-Area of Body ( )Right ( )Left __________

DATE OF ACCIDENT OR INJURY, IF ANY:__________

HOW INJURY OCCURRED: __________

EXISTING X-RAYS? YES____ NO____

IF YES, WHERE TAKEN__________

IS THIS AN ON-THE JOB INJURY? ( )YES ( )NO IF YES, DO YOU PLAN TO FILE A WORKERS COMP CLAIM?

INSURANCE: AS A COURTESY TO OUR PATIENTS, WE WILL FILE YOUR CHARGES WITH APPROPRIATE CARRIER IF COMPLETE INFORMATION IS GIVEN BELOW.

PRIMARY INSURANCE COVERAGE

Insurance Company Name __________

Address __________

____

ID Number __________

Group Numbers __________

Coverage Dates: From______ Thru ______

Subscribers Name __________

Subscriber Birth Date ____Relationship to Patient ______

Subscribers Social Security Number __________

Subscriber Employer Name __________

Address __________

____

____

SECONDARY INSURANCE COVERAGE

Insurance Company Name __________

Address __________

____

ID Number __________

Group Numbers __________

Coverage Dates: From______ Thru ______

Subscribers Name __________

Subscriber Birth Date ____Relationship to Patient ______

Subscribers Social Security Number __________

Subscriber Employer Name __________

Address __________

____

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AUTHORIZATION: I hereby authorize ORTHOPAEDIC ASSOCIATES OF DULUTH, P.A. to furnish information to insurance carriers concerning my illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

DATE____________________ SIGNATURE____________________