ORTHOPAEDIC SPECIALISTS OF NORTH CAROLINA

Date _____ PATIENT REGISTRATION FORM Chart # _____

Patient_____ _____ _____ Preferred Name _____
Last Name First Name MI

Street Address_____City _____ST _____Zip_____

Home Phone (_____)_____-_____ Work Phone (_____) _____-_____ Sex: Male or Female

Cell Phone (_____)_____- _____ Email Address _____

DOB:___/___/____SS# _____/_____/_____ Race: B W A H Other_____Marital Status: M S D Sep W

Employer Name and Address:_____

In case of an emergency, who should we contact? _____
Name Phone Relationship

Who referred you to our office? _____
Name Address Phone

Who is your Primary Care Physician? _____
Name Address Phone

<u>Primary Insurance Information</u>:

Name of Company_____
Address_____City_____ST_____Zip_____
Policy Holder's Name_____ Relationship to Patient_____
Policy Holder's Employer and Address_____
Policy Holder's DOB ____/_____/_____ SS#_____/_____/_____ ID#_____ Group#_____

<u>Secondary Insurance Information</u>:

Name of Company_____
Address_____ City_____ST_____ Zip_____
Policy Holder's Name_____ Relationship to Patient_____
Policy Holder's Employer and Address_____
Policy Holder's DOB_____/_____/_____ SS#_____/_____/_____ ID#_____Group# _____

<u>Worker's Compensation Information</u>:

Name of Company_____
Address_____City_____ST_____Zip_____
Date of Injury_____/_____/_____ Employer at time of accident_____
Employer's Address_____ City_____ ST_____Zip_____
Contact Person_____ Phone(_____) _____-_____ Extension ____

I consent to treatment necessary for the care of the above named person for whom I am legally responsible. I authorize the release of all medical records to the referring or primary care physician, or to other physicians as required for treatment and to my health insurance company, if applicable. I authorize transmission of medical information by fax. Any other release of medical information with neccessitate a specific written authorization by me. I authorize any health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I acknowledge full financial responsibility for services rendered by Orthopaedic Specialists of NC. I understand that payment of charges incurred is due at the time of service unless other defined financial arrangements have bee made prior to treatment. I further authorize and request that insurance payments be made directly to Orthopaedic Specialists of NC. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature:_____ Date _____/_____/_____
(Seal)

I have received ORTHOPAEDIC SPECIALISTS OF NC'S Notice of Privacy Practices.

Signature_____ Date_____/_____/_____