

ORTHOPAEDIC SPECIALISTS OF NORTH CAROLINA

PATIENT REGISTRATION FORM

Date _____

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

Primary Insurance Information:

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# _____

Secondary Insurance Information:

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# _____

Worker's Compensation Information:

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 necessitate 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 ____/____/____