

ORTHOPEDIC SURGERY, P.C. REGISTRATION FORM

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Best Phone # to Reach You? _____ Other #s: _____

Social Security #: _____ Male/Female Birth Date: _____ Age _____ Marital Status: _____

If patient is a minor, write the name and address of the person responsible for the bill: _____

Patient's Employer: _____ Employer's Phone: _____

Employer's Address: _____

Relative or Friend not living with you: _____ Phone: _____

NEW PATIENT _____ **ESTABLISHED PATIENT/NEW INJURY** _____ Today's Date: _____

Reason for Visit: _____ Date Problem Began: _____

If an injury, did it occur at work? _____ If so, the date the injury was reported to employer: _____

(See second page) **Was the injury the result of an accident?** _____ How? _____

(See second page) If you have an attorney, list name, telephone number, and address: _____

Have you been seen in the Emergency Room or a Hospital? _____ Which one? _____ When? _____

MD on call? _____ X-rays or MRI done? _____ Where? _____ If so, bring films to appointment _____.

PCP or Referring MD: _____ Phone # _____ Fax # _____

How did you hear about our practice? _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: _____ Type of Plan: _____

Telephone Numbers: _____ Group Number: _____

Identification Number: _____ Insured (if other than patient) _____

Relationship to Patient: _____ Insured's Soc. Sec. #: _____ Insured's Birth date: _____

Pt. advised to bring amount of unpaid deductible (or \$250 if deductible >\$500) to appt. _____

FOR OFFICE USE ONLY Staff Initials: _____ Date: ____/____/____ Time: _____

For HMO/POS: Referral #: _____ No. of Visits: _____ Expiration Date: _____

If SELF PAY, fees quoted? ___OV: \$75-200 ___X-Ray & Reading: \$75 - \$300 ___FX Care: \$200 - 800

(If surgery indicated, pt. advised that additional charges would be discussed at appointment time.)

Pt. advised to bring \$ _____ to appointment, or visit will need to be re-scheduled (if not an ER pt.).

Method of Payment? Cash / Check / Credit Card

Appt. Date: ____/____/____ **Time:** _____ **OFF.** _____ **TRC NBA BJA DAS KEH MCS** _____

Pt. advised to arrive at least 15-30 minutes early for paperwork _____ or directed to orthopedicsurgerypc.com? _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: _____ Type of Plan: _____
Telephone #s: _____ Group # _____ ID #: _____
Insured (if other than patient) _____ Relationship to Patient: _____
Insured's Soc. Sec.#: _____ Insured's Birth date: _____ Primary Care MD, and Phone #:

WORKERS' COMPENSATION INFORMATION

Name of Employer: _____ Address: _____
_____ Name of Contact Person: _____
Telephone #: _____ Fax #: _____ Verified? _____
Work Comp Insurance Carrier: _____ Verified? _____
Case Manager's/Adjuster's Name: _____
Phone #: _____ Fax #: _____ Claim #: _____
Billing Address: _____
Comments/Notes: _____

If an ACCIDENT

Patient's Med Pay benefits confirmed by _____ (name of pt's agent) at
_____ (name of ins. Co.) on _____ (date), telephone # _____.
Limits of med pay: \$ _____ Amount used: _____
Comments/Notes: _____
Health Insurance information attained (*see first page*) _____ or Self-Pay explained (*see first page*) _____

FOR OFFICE USE ONLY Verified by: _____ Date: _____ Effective Date of Coverage: _____
Ins. contact name: _____ Co-Pay _____ Pre-Existing? _____
Is co-pay due during global period? ___ No ___ Yes – under what circumstances? _____
How much is the deductible? _____ How much has been met? _____ Out of Pocket Max? \$ _____
Are outpatient procedures covered? _____ At what %? _____ Deductible apply? _____ Amt? _____
Are OVs covered? _____ At what %? _____ Deductible apply? _____ Amt? _____
Are X-Rays covered? _____ At what %? _____ Deductible apply? _____ Amt? _____
Are surgery code injections covered? _____ At what %? _____ Deductible apply? _____ Amt? _____
Is DME covered? _____ At what %? _____ Deductible apply? _____ Amt? _____ Out of Network Benefits:
_____ Billing Address: _____
For HMO/POS: Name of PCP: _____ Phone #: _____

Patient's Name: _____ Date: _____ Revised 07/09