

TRISTATE ORTHOPAEDIC TREATMENT CENTER

PATIENT REGISTRATION FORM

Please print or write legibly. All sections must be completed to satisfy the requirements necessary to treat and bill on your behalf. Please complete all areas so your treatment can be properly documented and represented. Thank you for your cooperation.

PATIENT INFORMATION

First Name	MI	Last Name	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
				<input type="checkbox"/> Married
Street Address / Apt #		City, State, Zip	Telephone Number	
		Cell Phone Number		
Birth Date	Sex	Social Security Number	Email Address	
			M F	
Employer	Address, City, State, Zip		Work Phone Number	
Spouse's Name	Spouse's Employer		Employer Phone number	

RESPONSIBLE PARTY Please complete with Insured Parent information for minors.

Name	<input type="checkbox"/> SELF	Relationship to Patient	Birth Date	Social Security Number
Street Address / Apt #		City, State, Zip	Telephone Number	
Employer	Address, Suite #, City, State, Zip		Telephone Number	

PRIMARY INSURANCE

Name of Insurance	Certificate/Policy/ID	Group Number	
Subscriber First Name	Last Name	Birth Date	Social Security Number
		Relationship to Patient	

SECONDARY INSURANCE Worker's Compensation/Auto Accident Patients please list Personal Insurance as Secondary.

Name of Insurance	Certificate/Policy/ID	Group Number	
Subscriber First Name	Last Name	Birth Date	Social Security Number
		Relationship to Patient	

WORKER'S COMPENSATION/AUTO ACCIDENT Patient is responsible regardless of insurance benefits or settlement

BWC Claim Number / Auto Insurance Policy Number	Company/Employer at Time of Accident	Date of Injury/Accident
Insurance Company Name	Phone Number	Have you notified your employer of accident? Y N
		Have you been treated for this injury? Y N
Attorney Name:		Telephone Number

FAMILY AND REFERRING PHYSICIAN INFORMATION

Referring Physician: First Name	Last Name	<input type="checkbox"/> NONE	Complete Address	Phone Number
Family Physician: First Name	Last Name	<input type="checkbox"/> NONE	Complete Address	Phone Number

PLEASE TURN PAGE OVER. THANK YOU.

EMERGENCY CONTACT

Name of friend or relative who does not live with you	Relationship to Patient
Complete Address	Phone Number

PLEASE CHECK ONE FROM EACH CATEGORY

Marital Status Single Married Unknown Widowed Divorced Separated

Employment Status Full-time Part-time Retired Unemployed
 Full-time Student Part-time Student Homemaker Disabled

Race Asian African American Caucasian Hispanic
 Native American Other _____ Unknown

How did you hear about our Physicians or our office?

Family/Friend _____

Other Physician _____

Yellow Page Ad Mailing to my home Newspaper Ad Health Insurance Directory

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am fully responsible for all charges incurred, regardless of my insurance status, for professional services rendered. This release is in effect one year from date signed.

Signature: _____ Date: _____
Patient or Authorized Representative

MEDICARE PATIENTS ONLY

Name of Beneficiary: _____ HI Claim Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to Tristate Orthopaedic Treatment Center for any services furnished to me by that physician. I authorize any holder of medical information, concerning me, to release this information to the Health Care Financing Administration and its agents. This information will be used to determine payable benefits.

I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVII of the Social Security Act.

Signature: _____ Date: _____

We will continue to provide quality Healthcare to our patients. We will endeavor to accommodate a patients request, however, due to Tristate Orthopaedic and Treatment Center being a surgical practice, patient emergencies and unforeseen situations are not uncommon and are beyond your doctors control, it may be necessary to reschedule or delay your appointment time. We apologize for any inconvenience this may cause you.