ORTHOPAEDIC ASSOCIATES, INC. PATIENT REGISTRATION

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Patient Name_____ Birth Date _____/____/_____ Age_____ Sex_____

Address_____Phone (_____)_____

City_____ State_____ Zip Code_____ SS# _____

Cell Phone (_____)_____Emergency Contact # (_____)_____

Date of Injury_____ **E-Mail_(required)_____**

Who referred you to our facility for today's appointment _____

Primary Care Dr._____Cardiologist (if applicable)_____

PLEASE COMPLETE INSURANCE INFORMATION BELOW:

PRIMARY INSURANCE

Name of Insurance Co._____

ID Number_____Group Number_____

Name of Policy Holder _____Birth Date_____/_____/_____

SECONDARY INSURANCE

Name of Insurance Co._____

ID Number_____Group Number_____

Name of Policy Holder _____Birth Date_____/_____/_____

WORKER'S COMPENSATION INFORMATION (IF APPLICABLE)

Was an accident report filed?_____Claim #_____Date of Injury_____/____/_____

Work Related Insurance Co. (MCO or self-insured)_____

Employer (at time of injury)_____Employer Phone (_____)_____

Address_____

City_____ State_____Zip Code_____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to Orthopaedic Associates, Inc. This assignment will remain in effect until revoked by me in writing. I hereby authorize Orthopaedic Associates, Inc. to release any/all information necessary to secure payment of said benefits. I understand that I am financially responsible for all charges/services whether or not paid by said insurance, including Worker's Compensation claims. Charges may include all medical, surgical, physical and occupational therapy services.

Please note that Orthopaedic Associates, Inc. will NOT bill or refund any balance of $5.00 or less

_____ _____

Signature Date

2/13/06