ADVANCED ORTHOPAEDIC ASSOCIATES, P.A.

PATIENT REGISTRATION

DR_____ DATE _____ TIME _____CHART #_____

PATIENT INFO

NAME - LAST	FIRST	MIDDLE	SS #	SEX	BIRTH DATE	AGE

STREET ADDRESS	HOME PHONE ( )	WORK PHONE ( )

CITY	STATE	ZIP CODE	CELL PHONE ( )	EMAIL

EMPLOYER	MARITAL STATUS	STUDENT (CHECK ONE) ☐ YES ☐ NO	PREFERRED LANGUAGE

ADDRESS	FAMILY CONTACT NAME	CONTACT RELATIONSHIP

CITY	STATE	ZIP CODE	CONTACT CELL PHONE ( )	CONTACT WORK PHONE ( )

Race (check one - Gov't Required)
☐ African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ White ☐ Other

Ethnicity (check one - Gov't Required)
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

GUARANTOR

NAME	EMPLOYER

ADDRESS	ADDRESS

CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE

RELATION TO PATIENT	SOCIAL SECURITY NUMBER	WORK PHONE	HOME PHONE

MUST COMPLETE: IN CASE OF EMERGENCY, NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU	PHONE	RELATIONSHIP

INSURANCE

INSURANCE (Please check one):
☐ No Coverage ☐ Auto Insurance ☐ BCBS ☐ CHAMPUS ☐ HMO ☐ Medicaid ☐ Medicare ☐ PPO ☐ Workman's Comp. ☐ Other

PRIMARY COMPANY	**SECONDARY COMPANY**

ADDRESS	ADDRESS

CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE

SUBSCRIBER'S NAME	D.O.B.	SEX	SUBSCRIBER'S NAME	D.O.B.	SEX

POLICY #	POLICY #

ID #	GROUP #	ID #	GROUP #

SS #	RELATION TO PATIENT	SS #	RELATION TO PATIENT

REFERRAL INFO

REFERRING PHYSICIAN - (CHECK BOX IF REFERRED THRU ER) ☐ ER				CITY, STATE

X-RAYS ☐ YES ☐ NO	X-RAY TAKEN AT	X-RAY DATE	X-RAYS WITH PATIENT ☐ YES ☐ NO	FAMILY PHYSICIAN - CITY, STATE

ACCIDENT ☐ YES ☐ NO	ACCIDENT OCCURRED ☐ WORK ☐ HOME ☐ AUTO ☐ OTHER	ACCIDENT STATE	ACCIDENT DATE	REASON FOR SEEING DOCTOR

ATTY INVOLVED ☐ YES ☐ NO	IF YES, ATTORNEYS NAME AND PHONE NUMBER

SIGNATURES

RELEASE OF MEDICAL INFORMATION

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to Advanced Orthopaedic Associates, P.A., for the surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed my indebtedness to Advanced Orthopaedic Associates, P.A., for those services.

INSURANCE INFORMATION RELEASE AUTHORIZATION: I hereby authorize Advanced Orthopaedic Associates, P.A., to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company or employer.

FINANCIAL AGREEMENT: I understand that I am responsible for all fees, regardless of insurance coverage. See separate Financial Policy/Agreement.

PATIENT'S SIGNATURE: _____ DATE _____

INSURED'S SIGNATURE (if other than patient) _____ DATE _____