

Orthopedic Associates of Southwestern Ohio, Inc.

Patient Registration Form

DATE:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SS#
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE ()	WORK PHONE ()	SEX M F	MARITAL STATUS M W S D	
SPOUSE'S NAME	SPOUSE'S EMPLOYER	SPOUSE'S WORK PHONE ()		
REFERRING PHYSICIAN (FULL NAME)			REFERRING PHYSICIAN PHONE ()	
REFERRING PHYSICIAN ADDRESS (INCLUDE STREET, CITY, STATE, ZIP)				
FAMILY PHYSICIAN (FULL NAME)			FAMILY PHYSICIAN PHONE ()	
FAMILY PHYSICIAN ADDRESS (INCLUDE STREET, CITY, STATE, ZIP)				
EMPLOYER			EMPLOYER PHONE ()	
EMPLOYER ADDRESS (INCLUDE STREET, CITY, STATE, ZIP)				
PATIENT OCCUPATION AND JOB DUTIES				
HOW DID YOU HEAR ABOUT OUR OFFICE?				
WHY ARE YOU BEING SEEN TODAY?				
IS THE INJURY/AFFECTED AREA ON THE RIGHT OR LEFT SIDE?				

WORKER'S COMPENSATION ONLY (COMPLETE THIS SECTION)

IS THIS WORK RELATED? YES _____ NO _____		DATE OF INJURY _____
PLACE OF EMPLOYMENT AT TIME OF INJURY: _____		
HOW DID INJURY OCCUR? _____		
PLEASE STATE CURRENT PROBLEM: _____		
IS THE INJURED/AFFECTED AREA ON THE RIGHT OR LEFT SIDE? _____		
IS YOUR COMPANY SELF-INSURED? YES _____ NO _____		
ADDRESS OF EMPLOYER _____		
EMPLOYER PHONE NUMBER: () _____	EMPLOYER FAX NUMBER: () _____	
MANAGED CARE ORGANIZATION (MCO) NAME AND ADDRESS FOR WORKER'S COMPENSATION: _____		
MCO PHONE NUMBER: () _____	MCO FAX NUMBER: () _____	
IS AN ATTORNEY REPRESENTING YOU? YES _____ NO _____		
IF YES, ATTORNEY'S NAME AND FULL ADDRESS: _____		
ATTORNEY PHONE NUMBER: () _____	ATTORNEY FAX NUMBER: () _____	

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SS#
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE ()	WORK PHONE ()	SEX M F	MARITAL STATUS M W S D	
EMPLOYER			EMPLOYER PHONE ()	
EMPLOYER ADDRESS (INCLUDE STREET, CITY, STATE, ZIP)				

EMERGENCY CONTACT (PERSON NOT LIVING WITH YOU)

NAME	PHONE NUMBER ()	RELATIONSHIP
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INSURANCE/POLICY HOLDER (PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST)

PRIMARY INSURANCE COMPANY	POLICY HOLDER	POLICY HOLDER EMPLOYER	
INSURANCE ADDRESS (INCLUDE STREET, CITY, STATE, ZIP)			
INSURANCE PHONE	GROUP NUMBER	POLICY NUMBER	
POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SS#	RELATIONSHIP TO PATIENT	WORK PHONE ()

SECONDARY INSURANCE

SECONDARY INSURANCE COMPANY	POLICY HOLDER	POLICY HOLDER EMPLOYER	
INSURANCE ADDRESS (INCLUDE STREET, CITY, STATE, ZIP)			
INSURANCE PHONE	GROUP NUMBER	POLICY NUMBER	
POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SS#	RELATIONSHIP TO PATIENT	WORK PHONE ()

MEDICARE PATIENTS ONLY (COMPLETE THIS SECTION)

ARE YOU CURRENTLY WORKING? YES _____ NO _____ EMPLOYER: _____

DO YOU HAVE INSURANCE THROUGH YOUR EMPLOYER? YES _____ NO _____

IS YOUR SPOUSE CURRENTLY WORKING? YES _____ NO _____ EMPLOYER: _____

DO YOU HAVE INSURANCE THROUGH YOUR SPOUSES EMPLOYER? YES _____ NO _____

IS YOUR VISIT TODAY RELATED TO AN ACCIDENT OR INJURY? YES _____ NO _____

IF YES, DO YOU HAVE ANOTHER INSURANCE COMPANY RESPONSIBLE FOR TODAY'S BILL? YES _____ NO _____

IF YOU ANSWERED YES TO ANY QUESTIONS ABOVE, PLEASE PROVIDE INSURANCE INFORMATION TO THE RECEPTIONIST.

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis and general treatment (including but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of **Orthopedic Associates of Southwestern Ohio, Inc.** If necessary, I also give my permission for any allied health professionals (physician assistant, orthopedic technician, radiology technician, etc.) to review my medical records for the purpose of evaluating my overall health needs. I realize that if medical procedures or surgery is required, I will be given additional information. I hereby authorize **Orthopedic Associates of Southwestern Ohio, Inc.** to furnish information from my medical records to my insurer, Worker's Compensation carrier or health care agency which may be providing financial assistance in my care.

I hereby authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agent, any information needed in determining those benefits payable for related services. I hereby authorize Medicare to furnish to **Orthopedic Associates of Southwestern Ohio, Inc.** any information regarding my Medicare claims under title XVII of the Social Security Act.

FINANCIAL AGREEMENT

All charges are my responsibility. I assign and authorize payment to be made directly to **Orthopedic Associates of Southwestern Ohio, Inc.** of all insurance benefits and agree to pay any balance due.

I have read the above. I understand and accept these terms. If I refuse treatment or leave the facility, I hereby release the physician and **Orthopedic Associates of Southwestern Ohio, Inc.** of all responsibility for my action. I am aware of the above contents but understand that, except to the extent that action has been taken based on my authorization, I may withdraw my authorization at any time by written notification to the parties involved.

SIGNATURE OF PATIENT (RESPONSIBLE PARTY)

DATE