

ANNE ARUNDEL ORTHOPAEDIC SURGEONS

PATIENT REGISTRATION

(PLEASE PRINT CLEARLY)

PATIENT'S NAME – FIRST			MIDDLE		LAST		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
HOME ADDRESS – STREET				APT. #		CITY			STATE		ZIP
HOME PHONE		WORK PHONE			CELL PHONE			EMAIL ADDRESS			
DATE OF BIRTH		AGE		SOCIAL SECURITY NUMBER			OCCUPATION				
EMPLOYER			ADDRESS – STREET			CITY			STATE		ZIP
SPOUSE OR PARENT NAME		SPOUSE OR PARENT EMPLOYER		ADDRESS				WORK PHONE			
IN CASE OF EMERGENCY NOTIFY		ADDRESS				HOME PHONE		WORK PHONE			
FINANCIALLY RESPONSIBLE PERSON <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER					NAME (IF DIFFERENT THAN PATIENT)						
ADDRESS (IF DIFFERENT FROM PATIENT)						HOME PHONE		WORK PHONE			

HEALTH INSURANCE INFORMATION

IS INJURY <input type="checkbox"/> JOB RELATED <input type="checkbox"/> RESULT OF AUTO ACCIDENT <input type="checkbox"/> PERSONAL ACCIDENT INVOLVING LIABILITY										
HEALTH INSURANCE CO. NAME			INSURANCE CO. ADDRESS							
ID/POLICY NO.			GROUP NO.				EFFECTIVE DATE			
POLICYHOLDER		POLICYHOLDER'S RELATION TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				SOCIAL SECURITY NO.		DATE OF BIRTH		
INSURED'S EMPLOYER		ADDRESS						WORK PHONE		
SECONDARY INSURANCE COVERAGE		INSURANCE CO. ADDRESS								
ID/POLICY NO.			GROUP NO.				EFFECTIVE DATE			
POLICYHOLDER		POLICYHOLDER'S RELATION TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				SOCIAL SECURITY NO.		DATE OF BIRTH		
INSURED'S EMPLOYER		ADDRESS						WORK PHONE		

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM AND DO ASSIGN TO THE DOCTOR ALL MONEY TO WHICH I AM ENTITLED FOR MEDICAL AND/OR SURGICAL EXPENSES RELATIVE TO THIS CASE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTOR FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

PAYMENT FOR ORTHOPAEDIC CONSULTATION OR OFFICE VISIT REQUESTED AT THE TIME OF SERVICE.

15% ATTORNEY FEE IF REFERRED FOR COLLECTIONS.

SIGNATURE _____ DATE _____

INTEROFFICE USE

ACCT# _____

DOCTOR _____

RECEPTIONIST _____

DATE _____

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INSURANCE INFORMATION – COMPLETE APPROPRIATE SECTION(S)

IS INJURY JOB RELATED RESULT OF AUTO ACCIDENT PERSONAL ACCIDENT INVOLVING LIABILITY

IF INJURY IS RELATED TO ANY OF THE ABOVE, PLEASE COMPLETE APPROPRIATE SECTION, OTHERWISE READ AND SIGN LAST SECTION.

FOR WORK RELATED INJURIES

EMPLOYER AT TIME OF ACCIDENT		DATE OF INJURY
ADDRESS		PHONE
WAS INJURY REPORTED TO SUPERVISOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF SUPERVISOR	
DESCRIPTION OF INJURY		
ATTORNEY'S NAME	PHONE	
ADDRESS		
WORKER'S COMPENSATION CARRIER		
ADDRESS	ADJUSTOR'S NAME	
CLAIM NUMBER	PHONE	

FOR AUTO OR PERSONAL ACCIDENT (LIABILITY)

DATE OF ACCIDENT	LOCATION/DESCRIPTION OF ACCIDENT
YOUR AUTO INSURANCE CO.	
PIP CARRIER	INSURED
ADDRESS	ADJUSTOR'S NAME
CLAIM #	PHONE
ATTORNEY'S NAME	PHONE
ADDRESS	
OTHER INSURANCE CO.	INSURED
ADDRESS	ADJUSTOR'S NAME
CLAIM #	PHONE

I HAVE COMPLETED THIS FORM FULLY AND COMPLETELY, AND CERTIFY THAT I AM THE PATIENT OR DULY AUTHORIZED GENERAL AGENT OF THE PATIENT AUTHORIZED TO FURNISH THE INFORMATION REQUESTED. I UNDERSTAND THAT EVEN THOUGH I MAY HAVE SOME TYPE OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT OF SERVICE.

SIGNATURE _____ DATE _____