Atlantic Orthopaedic Specialists

Leading the Future in Orthopaedic and Physical Therapy

PATIENT REGISTRATION

Chart # _____ Today's Date _____ Physician's # _____

Patient's Name _____ Sex (check one) ☐ Male ☐ Female

Last *First* *Initial*

Father's Social Security # _____

Birthdate _____ Age _____ Patient's Social Security # _____ If none, Mother's S.S. # _____

Guarantor's Name _____

Patient's Address: Street _____

City _____ State _____ Zip _____

Guarantor's Address: Street _____

(If different from patient) City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____ Referring Physician _____

INSURANCE

	PRIMARY	SECONDARY	THIRD
Insurance Company			
Subscriber's Name			
Subscriber's Sex	[ ] M [ ] F	[ ] M [ ] F	[ ] M [ ] F
Subscriber's Birthdate			
Subscriber's SSN			
Relationship to Patient			
Policy Effective Date	From_____To_____	From_____To_____	From_____To_____
Policy #			
Group #			

Marital Status (check one) ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated

Have you been seen by any orthopaedic physician? ☐ YES ☐ NO If yes, who _____ when _____

How did you hear about our practice? ☐ Referring Doctor ☐ Friend/Family ☐ Hospital ER ☐ Attorney ☐ Advertisement ☐ Trainers Other (Please specify) _____

Patient's Complaint (describe accident or problem) _____

If an injury, date of injury _____ Date of first symptoms _____ Date any physician first consulted _____

(Check one) ☐ Work Related ☐ Auto Accident ☐ Other _____

If you are being treated for an accident/injury and you have an attorney, please give the name of your attorney _____

Treated at a Hospital? ☐ YES ☐ NO Name of Hospital _____

Were x-rays taken? (check one) ☐ YES ☐ NO Where are they located? _____

Patient or Guarantor's Employer Name _____ Occupation _____

Address _____

Spouse's Name and Employer _____ Work Telephone _____

Closest Relative or Friend Other Than Husband or Wife (Not in Home)

Name _____ Telephone _____

Address _____

PLEASE READ INFORMATION ON THE REVERSE SIDE OF THIS PAGE AND SIGN

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN

I HEREBY CONSENT TO TREATMENT by Atlantic Orthopaedic Specialists physicians, their associates, and/or assistant and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances, and/or such other procedures as deemed necessary.

I understand that payment (or co-payment) is expected at the time of service, and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not paid by this authorization. I further understand if a balance results on my account at the time of any litigation settlement relating to injuries for which I am being seen, my account with this practice will be the first bill paid in full at the time of settlement. Should any Atlantic Orthopaedic Specialists physician qualify and testify as an expert witness on my behalf, in any legal or administrative proceeding or deposition, including appearances cancelled within 7 days, I understand that I will be liable for such physician's fee as an expert witness. Should collection actions become necessary, I understand that I will be liable for all *costs*, including reasonable attorney fees associated in collecting the unpaid balance owing on my account.

I hereby authorize the release of any information necessary for filing of any insurance and direct payment to the Atlantic Orthopaedic Specialists physicians for any amounts due under my present policy(ies) or any policy that I may at a later date ask to be filed. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A copy of this authorization shall be considered as effective and valid as the original. I will advise Atlantic Orthopaedic Specialists of any changes in insurance coverage.

I also authorize Atlantic Orthopaedic Specialists to talk with and exchange information with other medical professionals regarding my medical condition. The medical professionals include, but are not limited to: physical therapists, occupational therapists, athletic trainers, nurses, physicians assistants, rehabilitation specialists, case workers, primary care physicians, referring physicians, and nurse practitioners.

If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I *agree* to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Signed: _____ _____ _____

Patient or Responsible Party | Date | Witness

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Atlantic Orthopaedic Specialists for any services furnished me by Atlantic Orthopaedic Specialists. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ _____ _____

Patient or Responsible Party | Date | Witness

Atlantic Orthopaedic Specialists files your insurance as a courtesy to you. If a co-payment or co-insurance is due from you, your insurance company, HMO, or managed care company requires us to collect this payment at the time of service. We accept cash, check, Mastercard, and VISA.