

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Acct# \_\_\_\_\_

### PATIENT REGISTRATION FORM Rochester Orthopedics

#### PATIENT INFORMATION

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ E-mail address \_\_\_\_\_

(not required)

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  Male  Female Age \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status  Single  Married  Widowed  Divorced

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone \_\_\_\_\_, Ext. \_\_\_\_\_ If student, school name \_\_\_\_\_

Is student  Full Time  Part Time

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**GUARANTOR/SPOUSE INFORMATION (if not above)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  Male  Female Age \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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**REFERRING PHYSICIAN**

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

**PRIMARY CARE PHYSICIAN IF DIFFERENT FROM REFERRING PHYSICIAN**

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

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Emergency Contact Name \_\_\_\_\_ Relationship to You \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Is the injury / illness related to work?  Yes  No If yes, date of injury \_\_\_\_\_

Is the injury / illness due to an accident?  Yes  No If yes, date of injury \_\_\_\_\_

Type of Accident Motor Vehicle (MVA) Other (please explain) \_\_\_\_\_

Referral Source  Family  Friend  Insurance Company  Phone Book  Other

Can we leave appointment reminders on the home number provided?  Yes  No

Can we contact you via e-mail?  Yes  No

**PRIMARY INSURANCE INFORMATION**

Name of Insurance Company \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Sex  Male  Female

**SECONDARY INSURANCE INFORMATION**

Name of Insurance Company \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Sex  Male  Female

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**Insurance Authorization and Assignment:** I hereby assign, to Rochester Orthopedics, payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

**Financial Agreement:** I understand that I am financially responsible for all charges whether or not they are covered by my insurance as well as any co-payment and co-insurance. In the event of non-payment for any of these costs, I understand I will be legally responsible for all costs involved with the collection of this account including all court cost, attorney fees, and any expenses incurred, should this be required.

**Consent to Treat:** I request and give consent to my physician to provide and perform such medical/surgical care, tests, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

**Medicare Certification:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Rochester Orthopedics for any services furnished me by that physician. 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 to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_