

South Shore Orthopedic Associates, P.C.

PLEASE PRINT

PATIENT REGISTRATION

Patient's Name _____ DOB _____ / _____ / _____ M F
Social Security Number _____
Street Address _____ Apt/Suite _____
City _____ State _____ Zip _____
Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Ext _____
Insurance Subscriber's Name _____
Patient's Relationship to Subscriber: Self ___ Spouse ___ Dependent Child ___ Other ___
How Were You Referred? _____

GUARANTOR (Insurance Subscriber) INFORMATION

Guarantor's Street Address _____ Date Of Birth _____
City _____ State _____ Zip _____
Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Ext _____
Subscriber's Employer _____
Employer's Address _____
City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____
Relationship to Patient _____
Address _____ Apt/Suite _____
City _____ State _____ Zip _____
Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Ext _____

Please Complete if applicable

WORKERS COMPENSATION

Carrier _____
Contact _____
Carrier's Address _____
City _____ State _____ Zip _____
Injury Date ____ - ____ - ____ Employer Group: _____ Claim # _____
Comments _____

ATTORNEY

Firm _____ Attorney _____
Address _____
City _____ State _____ Zip _____
Comments _____

MOTOR VEHICLE ACCIDENT

Auto Insurance Carrier _____
Address _____
City _____ State _____ Zip _____
Date of Accident ____ / ____ / ____ Policy # _____
Policy Holder _____ Carrier's Phone # ____ - ____ - ____

Physician/Pharmacy Info (IMPORTANT PLEASE COMPLETE)

Primary Care Physician _____ Phone # _____
Address _____ State _____ Zip _____
Pharmacy Name _____ Town _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance _____

Address _____

City _____ State _____ Zip _____ Phone # _____

Policy # _____ Group # _____

Name of Policy Holder: _____

Secondary Insurance _____

Address _____

City _____ State _____ Zip _____ Phone # _____

Policy # _____ Group # _____

Name of Policy Holder: _____

PATIENT CONSENT

I verify that the above information is accurate and agree to inform South Shore Orthopedic Associates of any changes that may occur as soon as I am aware of the changes.

AUTHORIZE FOR RELEASE OF INFORMATION TO PAYORS AND/OR CAREGIVERS:

I authorize South Shore Orthopedic Associates and any physician giving care to me or my dependent child, to release medical or other information necessary for the (1) completion of insurance claims or receipt of benefits, (2) review of the quality and appropriateness of my care by representatives of external agencies designated by law to conduct such reviews. I understand that South Shore Orthopedic Associates will forward copies of all or part of my medical record to any physician participating in my care and to any facility to which I may be admitted or transferred. If my care is related to an accident at work, I understand my employer's Worker's Compensation Carrier will also have access to information contained in my medical record.

ASSIGNMENT OF BENEFITS:

I authorize and request payment of medical benefits to be made directly to this office for services rendered. I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES rendered on my behalf or my dependents. I understand that my insurance carrier may require me to obtain a referral PRIOR to my visits. I also understand that if I FAIL TO OBTAIN RFEERRALS PRIOR TO MY VISITS, I WILL BE RESPONSIBLE FOR PAYMENT.

MEDICARE AUTHORIZATION: (Medicare Recipients Only)

I certify the information given to me in applying for payment of Medicare benefits under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that the payment of authorized benefits to be made on my behalf to South Shore Orthopedic Associates or any physician providing service during my treatment.

ACKNOWLEDGE OF RECEIPT-AN IMPORTANT MESSAGE FROM MEDICARE:

If I am Medicare eligible, my signature only acknowledges my receipt of this message from South Shore Orthopedic Associates and does not waive any of my rights to request a review or make me liable for any payment.

SIGNATURE:

I have read the information above or have had it read to me. I understand the information and my questions have been answered to my satisfaction. My signature below verifies that I voluntarily consent to the above.

Signature of Patient (Authorized Representative)	Relationship	Date
--	--------------	------

Witness: _____