Today's Date: __________

Last Name: _______________________ First Name ________________ MI _______
Social Security # ______-______-______ Date of Birth _____________ Age _______
Gender _____________ Marital Status: ______________________________
Race (optional): Black White Asian Hispanic American Indian Other
Address ____ Apt/Unit # _______
City ___________________________ State ________________ Zip ______________
Home Phone (_______) ______________ Cell Phone (____) __________________
Employer _________________________________ Occupation __________________

How did you hear about us? ______________________________________
If a physician referred you to us, please provide the name _______________________

EMERGENCY CONTACT
Name ______________________________ Relationship _________________________
Home Phone ________________________ Cell Phone __________________________

INSURANCE INFORMATION
Primary Insurance Co Name _______________________ Phone (____) ____________
Policy Holder's Name (if other than self) _____________________________________
Policy Holder's Relationship to Patient _______________________________________
Social Security # _______________________ Date of Birth _____________________
Policy/Member # _____________________________ Group # ___________________
Employer Providing Insurance ____

Secondary Insurance Co Name _____________________ Phone (____)____________
Policy Holder's Name (if other than self) _____________________________________
Policy Holder's Relationship to Patient _______________________________________
Social Security # _______________________ Date of Birth _____________________
Policy/Member # _______________________ Group # _________________________
Employer Providing Insurance ____

Primary Care Doctor
Name _____________________________
Phone # ____________________________
Date Last Seen ______________________

Preferred Pharmacy
Name _______________________
Phone # _____________________

**Continued on back

PATIENT REGISTRATION FORM

Patient Registration (continued):

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize SpecOrtho to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.
I have requested the medical service of **SpecOrtho** on behalf of myself and/or dependents, and I understand by making this request, I become fully financially responsible for any and all charges occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, Medicaid, private insurance and any other health/medical plan to issue payment directly to SpecOrtho for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage. **Initials: _________**

NOTICE OF PRIVACY

I acknowledge that upon request I received a copy of the **SpecOrtho** "Notice of Privacy Practices". I have read and understand all the above and agree to comply.

Initials: _________

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition. I request and authorize **SpecOrtho** to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established.

Initials: ________

RESPONSIBLE PARTY (Adult Present signing consent to treat if the patient is a minor or Power of Attorney is necessary)

Last Name ____________________________ **First Name** __________________________

Patient Relationship to Responsible Party _____________________________________

Social Security # __________________________________ **Date of Birth** ____________

Address ____ **Apt** ____________

City ____________________________________ **State** ____________ **Zip** ______________

Home Phone ______________ **Work Phone** ______________ **Cell Phone** ____________