

PATIENT REGISTRATION

Referring Physician: _____

Referring MD Phone #: _____

PATIENT NUMBER: _____

Primary Physician Name #: _____

Primary Physician Phone #: _____

NAME (Last, First, MI) _____ **SEX** M F

Date of Birth: _____ Age: _____ SS #: _____ Occupation: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mail Address (If Different): _____ City: _____ State: _____ Zip: _____

Phone #: _____ **Cell #:** _____ **E-Mail:** _____ **Marital Status:** _____

Employer: _____ Address: _____ Phone #: _____

Spouse/Parent/Guardian Name: _____ Phone #: _____

Parents Employer: Mother: _____ Phone #: _____

Father: _____ Phone #: _____

Allergies _____

IN CASE OF EMERGENCY CONTACT: NAME: _____ Phone #: _____

Have you previously been treated by any of these physicians : (CIRCLE)

Dr. Blyznak, Dr. Dubrow, Dr. Hanypsiak, Dr. Hindes, Dr. Kurtz, Dr. Muhlrud

Dr. Oliveto, Dr. Patel, Dr. Petraco, Dr. Puopolo, Dr. Schrank, Dr. Sileo

PRIMARY INSURANCE

Insurance Company: _____

Insurance Company Address: _____

Policy #: _____ Group #: _____

PERSON RESPONSIBLE FOR ACCOUNT: Last: _____ First: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Insured's Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Date of Birth: _____ **SS#:** _____ **ID #:** _____

OTHER INSURANCE

Insurance Company: _____ Policy #: _____ Group #: _____

Insurance Company Address: _____

Insured Name: Last: _____ First: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Employer: _____ Business Phone: _____ Date of Birth: _____ SS #: _____

FOR MEDICARE PATIENTS: IS THIS A MEDIGAP? YES: _____ NO: _____

WAS THIS INJURY RELATED TO EMPLOYMENT, A MOTOR VEHICLE ACCIDENT, SCHOOL INJURY (OR OTHER LIABILITY) _____

WHERE DID INJURY OCCUR? DESCRIBE CIRCUMSTANCES OF INJURY: (DATE, LOCATION, HOW DID IT HAPPEN?) _____

ARE YOU PURSUING LEGAL ACTION? _____

Assignment of Benefits: I irrevocably assign/authorize to Orthopedic Associates of L.I., LLP the following: a: all of my rights and benefits under Medicare or any insurance contracts for payment of services rendered to me by him, b: all information regarding my benefits under any insurance policy relating to his claims to be released to him, c: to file insurance claims on my behalf including Medigap, if applicable for services rendered to me, d: direct that all such payments go directly to him, e: to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities, f: I authorize the provider to release any information necessary to substantiate a claim. In the event my account goes to collection, I understand that I will be responsible for all collection fees including costs of an attorney. Any questions I may have concerning this assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

PATIENTS SIGNATURE (If minor, parent or guardian) _____

DATE _____

Revised 11/08

checked By: _____ Date: _____