

Orthopaedic Surgery Specialists, Ltd. - Adult Registration

X-Ray # _____

Today's Date ____ / ____ / ____ Date of Injury ____ / ____ / ____

Height _____ Weight _____ Occupation _____

Description of Problem/Injury _____

Result of Accident: Yes No Type of Accident: Auto Home School Other

Patient Information

Last name _____ First _____ Middle-I. _____

Sex: M F Date of Birth ____ / ____ / ____ Age _____ Social Security # _____

Home Address: _____ Employer Name: _____

Address _____

Address _____

City _____

City _____

State _____ Zip Code _____

State _____ Zip Code _____

Home Phone # () _____ Work/Alternate # () _____

Marital Status: Married Single Divorced Widowed

Spouse's Information

Last name _____ First _____ Middle-I. _____

Date of Birth ____ / ____ / ____ Social Security # _____

Employer Name: _____

Address _____

Home Phone # () _____

City _____

Work/Alternate # () _____

State _____ Zip Code _____

Emergency Contact

Nearest friend or relative not living with you _____

Phone # () _____ Relationship to patient _____

Over Please

Responsible Party (Insurance Carrier)

Last name _____ First _____ Middle-I. _____

Date of Birth ____/____/____ Social Security # _____

Home Address: _____ Employer Name _____

Address _____ Address _____

City _____ City _____

State _____ Zip Code _____ State _____ Zip Code _____

Home Phone # () _____ Work/Alternate # () _____

Relationship to patient: Husband Wife Patient Other _____

Primary Insurance

Secondary Insurance

Insurance Company _____

Insurance Company _____

Subscriber Name _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Date of Birth _____

Subscriber Social Security # _____

Subscriber Social Security # _____

I.D. # _____

I.D. # _____

Group #/Name _____

Group #/Name _____

Authorization

Benefits to Orthopaedic Specialists, Ltd.

I hereby authorize payments directly to Orthopaedic Surgery Specialists, Ltd. for the surgical and/or medical benefits. I also understand that I am responsible for any portion of my bill not covered by my insurance company, including Medicare.

Signature of Patient/Guarantor _____ Date _____

Who referred you to our office? (Your Progress Notes will automatically be mailed to the referring physician)

Relative _____
Name

Friend _____
Name

Physician _____
First Last

Address _____ Suite _____

City _____ State _____ Zip _____

Phone # () _____

Other _____