

Orthopaedic Surgery Specialists, Ltd. Pediatric Registration

X-Ray # _____

Date _____ Date of Injury _____

Patient's Height _____ Patient's Weight _____

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

Patient Information

Last name _____ First name _____ Middle-I. _____

Sex: Male Female Date of Birth ___/___/___ Age _____ Social Security # _____

Home Address:

_____ Home Phone # () _____
Address

City

_____ State _____ Zip Code

Mother's name _____ Work/Alternate Phone # () _____

Father's name _____ Work/Alternate Phone # () _____

Responsible Party (Insurance Carrier)

Last name _____ First name _____ Middle-I. _____

Date of Birth _____ Social Security # _____

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

Home Address: _____ Employer Name _____

Address

City

_____ State _____ Zip Code

Address

City

_____ State _____ Zip Code

Relationship to patient: Mother Father Other _____

Over Please

Primary Insurance

Insurance Company _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber Social Security # _____
I.D. # _____
Group #/Name _____

Secondary Insurance

Insurance Company _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber Social Security # _____
I.D. # _____
Group #/Name _____

Emergency Contact

Nearest friend or relative not living with you _____ Phone # () _____

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** _____

Authorization

Benefits to Orthopaedic Surgery 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 _____