

MIDWEST ORTHOPAEDICS

PATIENT REGISTRATION

PLEASE PRINT

File/Account No. _____

Dr. _____

Date _____

Patient Social Security # _____ / _____ / _____ Cell Phone & Pager # _____

A PATIENT INFORMATION							
Last Name		First Name			Middle Initial		
Street Address				Apt. #		Home Telephone: ()	
City		State	Zip Code		Work Telephone: ()		Ext.
Birth Date: MM / DD / YY		Birth Place:		Age	<input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: S M W D	
Name and phone number or Relative/Friend (in case of emergency)					Phone Number: ()		
Responsible Party (Who is responsible to pay this account?) If different from above Social Security # _____ / _____ / _____			Last Name		First Name		
Address			City		State		Zip Code
Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Employer					<input type="checkbox"/> M <input type="checkbox"/> F		
What part of your body is affected?					Which side? <input type="checkbox"/> Left <input type="checkbox"/> Right		
Date Problem began	Is injury related to: (check one) <input type="checkbox"/> Working Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Are you able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No Last day worked / /						
Referring Physician		Address				Phone Number: ()	
If student, name of school					Contact person		
City		State		Zip Code		Phone Number: ()	
Occupation			Employer of the insured				
Contact Person at Work					Phone Number ()		
Employer/Street Address							
City		State		Zip Code		Length of time in Position	

B ONLY IF YOUR INJURY IS WORK RELATED WILL YOU NEED TO COMPLETE THE FOLLOWING INFORMATION			
Bill is to be sent to:			Workman's Comp. Claim Number
Name of Work Compensation Carrier			
Street Address			
City		State	Zip Code
Phone Number ()		Phone Number ()	
Attorney's Name/Address (if Law Suit is involved)			Phone Number ()
Is your work: <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Heavy Physical <input type="checkbox"/> Other			

Please Complete Section C&D on Reverse Side

C INSURANCE INFORMATION AND AUTHORIZATION

WE WILL COPY YOUR INSURANCE CARDS.

If you did not bring insurance cards with you, the bill will remain your responsibility.

MEDICARE# _____ (if you have signed over your Medicare benefits to a Senior HMO plan, do not list Medicare or present your Medicare card. Present only your Senior Plan HMO card).

OR

First Insurance Company Name		Name of the Insured	
Insured Social Security #	Insured's Birthdate		Insured Group Number
Relationship to Patient		Insured Group ID #	
2nd Insurance Company Name		Name of the Insured	
Insured Social Security #	Insured's Birthdate	<input type="checkbox"/> M <input type="checkbox"/> F	Insured Group Number
Insured Group ID #		Medicaid # (9 Digit ID #)	
		Relationship to Patient	

D AUTHORIZATION

[If the undersigned is the patient] I voluntarily authorize the release of all my medical information, including any drug/alcohol, mental health and HIV/AIDS information contained therein, for the purpose of determining insurance and other benefits payable. I also consent that the payment of authorized insurance benefits or Medicare benefits be made on my behalf directly to Midwest Orthopaedics for any medical or surgical services furnished.

[If the patient is a minor] I authorize that treatment be given to _____. I voluntarily authorize the release of all his/her medical information including any drug/alcohol, mental health and HIV/AIDS information contained therein, for the purpose of determining insurance and other benefits payable. I also consent that the payment of authorized insurance benefits or Medicare benefits be made on his/her behalf directly to Midwest Orthopaedics for any medical or surgical services furnished.

Signature: _____ Date: _____

Relationship (if patient is a minor) _____

I fully understand and agree that the doctors' services are being rendered to me/the patient personally and, therefore I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and copays. In case I default on payment, I also agree to pay all expenses connected with collecting charges that are due.

Signature: _____ Date: _____

Confirmation of Registration _____

Patient Signature

Who Referred You or How Did You Hear About Midwest Orthopaedics and Your Doctor?

School _____ Anchor (location) _____

HMO/PPO (Which One) _____

ANOTHER DOCTOR (Which One) _____

MEDIA (Newspaper, Radio, Television, Etc.) _____

Other: _____