St.Charles Orthopedics

NO-FAULT REGISTRATION

Referring Physician:_____ Referring MD 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:_____
Home #:_____ Cell #:_____ E-Mail:_____
Marital Status:_____
Present Employer:_____ Work Phone _____
Work Address:_____ City:_____ State:____ Zip:_____

IS THIS A MANAGED CARE NO-FAULT POLICY? YES_____ NO_____ Date of Injury:_____
Date Symptoms Began:_____ What body part?_____
Have you ever injured this body part before? YES_____ NO_____
Location of Accident:_____
Holder of Insurance:
Name:_____
Address:_____
Insurance Company
Name:_____
Insurance Company Address:_____
Insurance Company Phone #:_____
File #:_____ **Policy #:**_____
Was the Accident reported to your Insurance Company: YES_____ NO_____
Did injury occur while working?: YES_____ NO_____
Were you hospitalized?: YES_____ NO_____
Name of Hospital:_____
Address of Hospital:_____
Dates of Hospitalization:_____
Were you disabled by this accident?: YES_____ NO_____
Date disability began:_____
Will an Attorney be contacting us?_____
(SHOULD NO FAULT BE DENIED)
Commercial Insurance Co.: Name:_____
Commercial Insurance Address:_____
Subscriber Name:_____
Subscribers Employer:_____
Employers Address:_____
Group #_____ ID#:_____
IN CASE OF EMERGENCY CONTACT: Name:_____ Relationship_____
Cell #:_____ home # _____ work # _____

Note: In consideration of services rendered or to be rendered to the above named patient, I hereby authorize and assign payment directly to Dr._____ , provider of health services. I authorize the provider to release all medical information necessary to substantiate a claim. In the event that the provider does not receive payment from the insurance company, due to denial for any reason, I understand I am personally responsible for payment of the provider's charges. I also understand that if I have not yet met my deductible under no-fault, that I am responsible for payment of such deductible, under my policy coverage. In the event my account goes to Collection, I understand that I will be responsible for all collection fees including the cost of an attorney.

SIGNATURE_____ DATE_____
PLEASE SIGN THE ATTACHED FORM (NF3) Checked By:_____ Date:_____
Revised 5/13