St.Charles Orthopedics

Referring Physician:______________________________
Referring MD Phone #:______________________________
Primary Physician Name #:___________________________
Primary Physician Phone #:___________________________

PATIENT REGISTRATION

PATIENT NUMBER:______________________________

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:_________

Pharmacy: ___________________________ Address:_________________________ Phone #:_______________________

Employer:___________________________ Address:_________________________ Phone #:_______________________

Spouse/Parent/Guardian Name:_________________________________ Phone #:_____________________

Parents Employer: Mother:_____________________________________ Phone #: _____________________

Father:_____________________________________ Phone #:__________________

Allergies____

Race________________________ Ethnicity________________________ Language_______________________

IN CASE OF EMERGENCY CONTACT:

NAME:_________________________________ Phone #:___________________

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 St. Charles Orthopedics 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.

PATIENT'S SIGNATURE (If minor, parent or guardian)___________________________________ DATE:______________

Checked By:_____________________ Date:_____________

Revised 11/5/15