

PATIENT REGISTRATION (Please type or print)

ACCOUNT NUMBER _____

DOCTOR: MJC JAZ PGG PGH

JJR MCM GDR WFS RWH

FAMILY PHYSICIAN and/or
REFERRED TO THIS OFFICE BY _____

PATIENT'S NAME _____ DATE OF BIRTH _____ AGE _____
Last First Middle

HOME ADDRESS _____
Street City State Zip County

SEX _____ SOCIAL SECURITY NUMBER _____ — _____ — _____ MARITAL STATUS: SINGLE MARRIED
 SEPARATED (X) DIVORCED WIDOWED

PATIENT EMPLOYMENT STATUS (Mark one) Employed Full-time (1) Employed Part-time (2) Not Employed (3)
 Self Employed (4) Retired (5) Active Military (6) Full-time Student (F) Part-time Student (P)

PATIENT'S EMPLOYER & EMPLOYER ADDRESS _____

HOME PHONE _____

RESPONSIBLE PERSON _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

EMPLOYER _____

EMPLOYER ADDRESS _____ PHONE _____

COMPLAINT (Area of body) Right Left _____

DATE OF ACCIDENT OR INJURY, IF ANY _____

HOW INJURY OCCURRED _____

IS THIS AN ON-THE-JOB INJURY? Yes No *If yes, do you plan to file a workers' compensation claim?* _____

EXISTING X-RAYS? Yes No
IF YES, WHERE TAKEN

As a courtesy to our patients, we will file your charges with the appropriate carrier if complete information is given below.

PRIMARY INSURANCE COVERAGE

SECONDARY INSURANCE COVERAGE

Insurance Company Name _____

Address _____

ID Number _____

Group Numbers _____

Coverage Dates: From _____ Thru _____

Subscriber Name _____

Subscriber Birth Date _____ Relationship to Patient _____

Subscriber Social Security Number _____

Subscriber Employer Name _____

Subscriber Employer Address _____

Insurance Company Name _____

Address _____

ID Number _____

Group Numbers _____

Coverage Dates: From _____ Thru _____

Subscriber Name _____

Subscriber Birth Date _____ Relationship to Patient _____

Subscriber Social Security Number _____

Subscriber Employer Name _____

Subscriber Employer Address _____

AUTHORIZATION: I hereby authorize ORTHOPAEDIC ASSOCIATES OF DULUTH, P.A. to furnish information to insurance carriers concerning my illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

DATE _____

SIGNATURE _____