Name:
Chart:
Date: DOB:

PATIENT REGISTRATION

Patient's Name:	Patient's Birthdate:	Age:	Sex:
Street Address and/or PO Box:	City:	State:	Zip Code:

******Is the Responsible Party address the same as above? YES / NO.**
IF NO, complete the last section on Page 2.

Patient's SSN:	Marital Status:	Preferred Language: (Circle one) English Spanish _____ Declined

Race (Circle one) African American / Black Caucasian / White American Indian Native Hawaiian Asian Declined

Ethnicity (Circle one) Hispanic Non-Hispanic Declined | Do you text? ☐ Yes ☐ No

Other than appointment reminders; how do you prefer to be contacted? ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email ☐ Mail ☐ Fax _____

Phone: Home	Phone: Cell	Phone: Work

Who should be contacted regarding appointments and tests? ☐ Self ☐ Other Name:	Phone:

Employer:	Employer Address:

Occupation:	May we contact you at work? YES ☐ NO ☐

Email Address:

Family Physician:	City:	Phone:
Referring Physician:	City:	Phone:
Pharmacy:	City:	Phone:
Parent / Guardian Name (if under 18):	Relationship:	Phone:

The following person/persons have authorization to my personal health information, including appointments and test results and are also my emergency contacts:

1 Name:	Relationship to Patient:	Phone:
2 Name:	Relationship to Patient:	Phone:

How did you hear about us? ☐ Physician NP / PA ☐ Friend Relative ☐ ER ☐ Newpaper Radio ☐ Yellow Pages ☐ Internet ☐ Billboard

INSURANCE INFORMATION - PLEASE PROVIDE INSURANCE CARD(S) TO THE RECEPTIONIST

Primary Insurance:	Policy Holder's Name:

Policy Holder's DOB:	Policy Holder's SSN:	Relationship to patient:
Policy Holder's Address (if different from patient):		

Secondary Insurance:	Policy Holder's Name:

Policy Holder's DOB:	Policy Holder's SSN:	Relationship to patient:
Policy Holder's Address (if different from patient):		

Is This A Work Injury or Liability Accident? Y ☐ N ☐	Date of Injury or Accident:	Have you filed OR do you intend to file a Work Comp / Liability claim? Y ☐ N ☐

IF YES TO THE ABOVE, PLEASE NOTIFY THE RECEPTIONIST UPON ARRIVAL

*****Physical and Occupational Therapy, MRI and DME products can be obtained at a facility of my choice.**

Name: _____ Date: _____

DOB: _____

Initials	
	Authorization for medical treatment: As a patient of the Orthopaedic Center, I do hereby voluntarily consent to such medical care and treatment encompassing standard diagnostic procedures, outpatient therapy, and the performance of any other procedures by the Orthopaedic Center, as their judgment deems medically advisable. I understand that if I have any questions regarding my examination I may request an explanation at any time. (Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.)

Initials	
	Release of Information: I understand that the Orthopaedic Center of Southern Illinois will make every effort to treat my medical information as confidential; however, I realize information must be shared with providers and/or individuals involved in my care or on the payment of my care. I understand this will include information found in my medical record, to include alcohol, drug abuse, communicable disease, including HIV status, and/or psychiatric diagnosis. I agree to the release of information in my medical record, and to the actual medical record documents, to the extent necessary for the following purposes: to those responsible for collecting and those responsible for the payment of my care. This may include a person, Medicare government agency, insurance company, health plan or employer sponsored group plan.

Initials	
	"No Show" Appointment Policy: A "No Show" is when a patient does not show up **or** does not call to cancel prior to the time of a scheduled appointment. ▪ All no shows will be documented in the patient's chart and the patient will be notified by letter of the missed appointment. If a 3rd no show should occur, the patient may be formally released from the office. ▪ When you are formally released from the office, the office will provide **only** emergency care for a period of 30 days.

Initials	
	Assignment of Benefits: In consideration of any and all medical services, care, drugs, supplies, equipment, and facilities furnished by the Orthopaedic Center of Southern Illinois and all attending physicians, I hereby irrevocably transfer to said Orthopaedic Center of Southern Illinois and all attending physicians, all Medicare/Insurance benefits now due and payable to me and/or surgical services rendered by physicians for whom the Orthopaedic Center of Southern Illinois is authorized to charge and bill. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I will also pay all costs and expenses of collection, including reasonable attorney fees. I hereby authorize electronic billing for all of my claims.

Responsible Party (if under 18) PLEASE PRINT	Relationship:	Phone:	
Responsible Party Street Address and/or PO Box:	City:	State:	Zip Code:

Signature - Relationship to Patient Date of Birth SSN Date

A copy of this signature is as valid as the original and is in effect until I revoke it.