Orthopaedic Surgery Specialists, Ltd. – Adult Registration

X-Ray # _____

Today's Date ____ /____ /_____ **Date of Injury** ____ /____ /_____

Height _____ **Weight** _____ **Occupation** _____

Description of Problem/Injury _____

_____

Result of Accident: Yes No **Type of Accident:** Auto ☐ Home ☐ School ☐ Other ☐

Patient Information

Last name _____ **First** _____ **Middle-I.** _____

Sex: M F **Date of Birth** ____/____ /_____ **Age** _____ **Social Security #** _____

Home Address:

_____
Address

_____
City

_____
State Zip Code

Employer Name: _____

_____
Address

_____
City

_____
State Zip Code

Home Phone # ( ) _____

Work/Alternate # ( ) _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Spouse's Information

Last name _____ **First** _____ **Middle-I.** _____

Date of Birth ____ /____ /_____ **Social Security #** _____

Employer Name:

_____
Address

_____
City

_____
State Zip Code

Home Phone # ( ) _____

Work/Alternate # ( ) _____

Emergency Contact

Nearest friend or relative not living with you _____

Phone # (____) _____ **Relationship to patient** _____

Over Please

Responsible Party (Insurance Carrier)

Last name _____ **First** _____ **Middle-I.** _____

Date of Birth ____/____/_____ **Social Security #** _____

Home Address:

_____
Address

_____
City

_____
State Zip Code

Employer Name _____

_____
Address

_____
City

_____
State Zip Code

Home Phone # ( ) _____ **Work/Alternate # ( )** _____

Relationship to patient: ☐ Husband ☐ Wife ☐ Patient ☐ Other _____

Primary Insurance

Insurance Company _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Social Security # _____

I.D. # _____

Group #/Name _____

Secondary Insurance

Insurance Company _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Social Security # _____

I.D. # _____

Group #/Name _____

Authorization

Benefits to Orthopaedic Specialists, Ltd.

I hereby authorize payments directly to Orthopaedic Surgery Specialists, Ltd. for the surgical and/or medical benefits. I also understand that I am responsible for any portion of my bill not covered by my insurance company, including Medicare.

Signature of Patient/Guarantor _____ **Date** _____

Who referred you to our office? (Your Progress Notes will automatically be mailed to the referring physician)

☐ **Relative** _____
Name

☐ **Friend** _____
Name

☐ **Physician** _____
First Last

_____
Address Suite

_____
City State Zip

Phone # ( ) _____

☐ **Other** _____