Patient Registration Form

Name: _____ Today's Date: _____ Male/Female
Circle one

Maiden Name: _____

Address: _____ City, State, Zip: _____

Home #: _____ Work #: _____ Cell #: _____
Permission to leave a message at: Home yes[ ] no[ ] Work yes[ ] no[ ] Cell yes[ ] no[ ]

Email: _____ Date of Birth: ____/____/____ Marital Status _____

Doctor/Primary Care Provider: _____ SS #: _____

Occupation: _____ Employer: _____

Person responsible for payment (if not the patient): _____

Responsible party address/city/state/zip: _____

Relationship: _____ Contact #: _____ Email: _____

I was referred by: _____ Other family members seen here _____

INSURANCE INFORMATION:

Primary Insurance: _____

Subscriber Name: _____ Relationship to patient: _____

ID#: _____ Group # _____

Secondary Insurance: _____

Subscriber Name: _____ Relationship to patient: _____

ID#: _____ Group #: _____

Emergency Contact Information

Name of local friend or relative: _____ Relation to patient _____

Phone Number (____) _____ Alternate Phone Number: (____) _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Orthopedic & Sports Specialists of Louisville, P.S.C. or insurance company to release any information required to process my claims.
I agree that Orthopedic & Sports Specialists of Louisville, P.S.C. or their contracted collection agency may contact me by phone at any of the telephone numbers associated with my account, including wireless telephone numbers, which could result in charges to me. I also authorize any text messages or e-mails, using any phone number or e-mail address I've provided to you. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient and/or Guardian Signature: _____ Date: _____