ACCESS SPORTS MEDICINE & ORTHOPAEDICS
PATIENT REGISTRATION FORM

Patients Name: First __________________ MI ____ Last ______________________ Date of Birth: ____________

Complete Address (PO Box/Street Address): ____

City: ________________________ State: __________ Zip: __________ Employer: ________________________

Home Phone: ___________________ Employer Phone: __________________ Cell/Other Phone: ________________

Patient's SS No.: ____________________ Marital Status: M __ S __ D__ W __ S/O__ Male: ___ Female ____

Primary Care Physician: ____________________________Who referred you to us? ___________________________

Email Address (to receive updates about our services)____

PARENT/LEGAL GUARDIAN INFORMATION (if patient is under the age of 18)

Guarantor's Name: ________________________________ Relationship to patient: ___________________________

Address: _________________________________ City: _____________________ State: ______ Zip: ______________

SS No. ___________________ D.O.B. ____________ Phone: _________________ Employer:___ __________________

EMERGENCY CONTACT INFORMATION

In case of emergency please contact: _________________________________ Phone: ______________________________

Relationship to patient: ____

INSURANCE INFORMATION

Please check here if you are a <u>SELF PAY</u> Patient (no insurance coverage): ____________
Please check here if this visit is the result of an accident involving third party liability: ______ Auto ______

Date of Injury: _____________ Type of Injury: ___________________________________

Please check here if this visit is the result of a work related injury/illness: ____ Date of Injury: __________
Name of employer at time of injury: ___________________________City: ________________State: ______

Primary Insurance: ___________________________	**Secondary Insurance: __________________________________**
Policy Holders Name:__________________________	**Policy Holder Name: __________________________________**
Policy ID #:____________________________________	**Policy ID #:____**
Policy Holder SS#: ____________________________	**Policy Holder SS#: ___________________________________**
Relationship to Patient: ________________________	**Relationship to Patient: ________________________________**
Policy Holder DOB: ___________________________	**Policy Holder DOB: ____________________________________**

I hereby authorize Access Sports Medicine and Orthopaedics to release any information in the course of my examination or treatment, and further authorize payment directly to the physician of the surgical and/or medical benefits. In consideration of medical services to be rendered, I agree to be bound by the following terms. Payment is due within thirty (30) days of the billing date, after which interest may be added to the unpaid balance at the rate of one and one half percent per month (18% annum) until paid in full. In the event this account is turned over to a collection agency or attorney for collections, I shall additionally pay all costs of collections, including reasonable attorney's fee.

Signature of Patient/Legal Guardian: ___________________________________Date: ___________________

I acknowledge that I have received a copy of the Patient's Notice of Privacy Practices: ___________________________