

UPPER BUCKS ORTHOPAEDIC ASSOCIATION

DATE _____

PATIENT REGISTRATION FORM – PLEASE PRINT

NAME: _____ BIRTHDATE _____ AGE _____ SEX: M/F

ADDRESS _____ SS# _____

PHONE: (H) _____ (W) _____ City _____ State _____ Zip _____ MARITAL STATUS: S / M / D / W

EMPLOYER _____ ADDRESS _____ City _____ State _____
Parent's employer if patient is a minor

SPOUSE'S/PARENT/GUARDIAN NAME: _____ WORK PHONE _____

ADDRESS _____ City _____ State _____ Zip _____

CONTACT IN AN EMERGENCY _____ PHONE _____

PREFERRED PHARMACY _____ ADDRESS _____

REFERRING PHYSICIAN _____ FAMILY PHYSICIAN _____

ADDRESS _____ City _____ State _____ PHONE _____

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PRIMARY INSURANCE: Medical Medicare MA Auto** Workers' Compensation**

COMPANY: _____ ADDRESS _____ City _____ State _____

GROUP #: _____ POLICY # _____

SUBSCRIBER _____ DOB _____ SS# _____

SUBSCRIBER ADDRESS _____

INSURED EMPLOYER _____ ADDRESS _____ City _____ State _____

**ADJUSTER NAME _____ PHONE _____

CLAIM # _____ ** DATE OF INJURY/ACCIDENT _____

.....
SECONDARY INSURANCE: Medical Medicare MA

COMPANY _____ ADDRESS _____ City _____ State _____

GROUP #: _____ POLICY #: _____

SUBSCRIBER: _____ DOB _____ SS# _____

SUBSCRIBER ADDRESS: _____

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ARE YOU TO BE TREATED FOR AN INJURY? Auto Work Motorcycle Sports _____

INFORMATION RELEASE

I authorize the release of any Medical Information necessary to process this claim and request payment of Medical Benefits to the undersigned physician for services rendered.

I authorize all benefit payments be made directly to Upper Bucks Orthopaedic Association. **I understand that I am financially responsible for any non-covered services and unpaid balances as well as DEDUCTIBLE and COINSURANCES as determined by MEDICARE/MEDIGAP or other insurance carrier.** I am also responsible for any and all collection fees if the account becomes delinquent.

SIGNATURE _____

DATE _____

Patient, Parent or Guardian