

UPPER BUCKS ORTHOPAEDIC ASSOCIATION

DATE _____

PATIENT REGISTRATION FORM – PLEASE PRINT

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

ADDRESS _____

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

E-MAIL ADDRESS: _____ SS# _____

EMPLOYER _____ OCCUPATION/POSITION _____
Parent's employer if patient is a minor

EMPLOYER'S ADDRESS _____
City _____ State _____

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

ADDRESS _____
City _____ State _____ Zip _____

CONTACT IN AN EMERGENCY _____ PHONE _____

PREFERRED PHARMACY _____ ADDRESS _____

REFERRING PHYSICIAN _____ FAMILY PHYSICIAN _____

ADDRESS _____ PHONE _____
City _____ State _____

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: _____

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 _____
Patient, Parent or Guardian

DATE _____

INFORMATION RELEASE

In an effort to continue to provide you with comprehensive quality care, and to comply with governmental policies, a signature is required to provide our practice the right and ability to retrieve a complete list of your medications from your pharmacy.

Please sign in the space indicated below, if you are willing to allow us to obtain this information.

SIGNATURE _____
Patient, Parent or Guardian

DATE _____