The Centers
for Advanced Orthopaedics
The Orthopaedic Center Division

Date of Birth:
Appointment Date:

Patient Registration

***Please return completed paperwork to the front desk with the patient's photo ID and insurance card(s). Thank you*

Today's Appointment:

Physician:

Body Part(s): ______________________

Is your current problem a result of a car accident or work injury? ________

Date of Injury or Accident: ________

Account # ________ **Patient Name:**	**Cell Telephone #:** ________ **Home/Work Telephone #:**
Date of Birth: **Age:** **Patient Sex:**	**Email Address: (please print)**
Address:	**City, State & Zip Code:**
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Emergency Contact Name & Phone:** ________ **Relationship to Patient:**
Employment / Student Status: ☐ Full time employed ☐ Full time student ☐ Part time employed ☐ Part time student ☐ Unemployed ☐ Retired	**Employer Name & Address:** ________ ________ **Occupation:**
Referring Physician: ________ **Family Physician:** ________	☐ **Married** ☐ **Single** ☐ **Other** **Spouse's Name:**
Ethnicity of Patient: ☐ **Hispanic Origin** ☐ **Non Hispanic Origin** ☐ **Unknown** ☐ **Declined to Answer** **Preferred Language of Patient:** ☐ **English** ☐ **Spanish** ☐ **Other** ________	**Race of Patient:** ☐ **American Indian/ Alaskan Native** ☐ **Asian** ☐ **Black/ African American** ☐ **Native Hawaiian/ Other Pacific Islander** ☐ **White** ☐ **Unknown** ☐ **Declined to answer**

In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

Financially Responsible Person (if different from above)

Full Name: ________	**Social Security Number:** ________
Address: ________	**Cell Telephone #:** ________
City, State & Zip Code: ________	**Home Telephone #:** ________
Date of Birth: ________	**Work Telephone #:** ________
Employer Name:	**Relationship to the Patient: (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

All conversations between the patient and the physician may be recorded for the purposes of having an accurate transcript for the patient record.

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Insurance Information

(Please verfiy that the information we have on file is correct)

Primary Insurance Company Name:		**Secondary Insurance Company Name:**	
Address, City, State & Zip:		**Address, City, State & Zip:**	
Policy Holder:	**Date of Birth:**	**Policy Holder:**	**Date of Birth:**
Policy Holder Employer:	**Policy Holder SSN:**	**Policy Holder Employer:**	**Policy Holder SSN:**
Policy Number:	**Group Number:**	**Policy Number:**	**Group Number:**
Relationship to the Patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		**Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

Consent to Treatment

By signing this form, I consent to be treated by the providers of The Orthopaedic Center. I understand that my medical provider needs a complete medical history regarding my health. I ask for and allow the medical providers and staff of The Orthopaedic Center to provide me with the needed medical treatment and services recommended by my physician or physician assistant. I understand that treatment and services may include, but is not limited to the following:

- **routine exams** • **diagnostic tests** • **casts/splints** • **injections** • **lab tests** • **x-rays** • **screening tests**

I understand that no guarantee can be made about the results of any treatment or services provided.

Signature ______________________ Date ______________

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to The Orthopaedic Center, a division of The Centers for Advanced Orthopaedics, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature ______________________ Date ______________

Medicare Patients

If you are covered by Medicare, please read and sign the following:
In Medicare cases, The Orthopaedic Center, a division of The Centers for Advanced Orthopaedics, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature ______________________ Date ______________