# *Southern Orthopaedic Specialists*

## Patient Registration Form

### Patient Information

Name _____ _____ _____ ☐ Male ☐ Female
Last First Middle

Address _____ _____
City State Zip

Home Ph (_____) _____ Cell ph (_____) _____ Work Ph (_____) _____

Date of Birth _____ /_____/_____ SS#: _____-_____-_____ Single Married Widowed
(Circle One)

**Email Address:** _____ **Primary Care Physician:** _____

**Language:** ☐ English ☐ Spanish ☐ Vietnamese ☐ French ☐ Other: _____

**Race:** ☐ Hispanic ☐ Asian ☐ Caucasian ☐ African American ☐ Other: _____

**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Other

### Person Responsible or Insured Party

Check if Self ☐
(If different from Patient)

Name _____ _____ _____ _____/_____/_____
First M Last Date of Birth

Address _____ _____
City, State, Zip

Relationship _____ Social Security # _____-_____-_____

### Spouse

Name _____ _____/_____/_____ (_____) _____
First, Last Date of Birth Phone

### Employment

_____ _____
Company or School Address City, State, Zip

If Student: ☐ Full Time ☐ Part Time

### Emergency Contact (if different than spouse)

_____ (_____)_____ _____
Name Phone Relationship

***Please Continue on Page 2***

# INSURANCE INFORMATION

## Primary Insurance

_____
Insurance Carrier

_____
Address

_____
City State Zip

_____
Name of Insured (if different from patient)

_____/_____
Policy # Group #

## Secondary Insurance

_____
Insurance Carrier

_____
Address

_____
City State Zip

_____
Name of Insured (if different from patient)

_____/_____
Policy # Group #

## Who can we thank for referring you?

☐ Referred by Patient ☐ Referred by Physician

_____
Name

_____
Address (if available)

_____
City State Zip

I would like to have copies of my Medical Records sent to my Primary Care Physician:

_____
Name

_____
Address (if available)

_____
City State Zip

*Authorization to Pay Benefits to Physician:* I hereby authorize Southern Orthopaedic Specialists to furnish information to insurance carriers concerning my illnesses and treatment, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I understand that if co-payments, deductibles, out of pocket expenses, non-covered services and balance due after insurance payments are due at the time of service, unless prior arrangements have been made. A photocopy of this authorization and assignment may be honored as valid. This authorization is valid until revoked by me in writing.

*Authorization to Release Information:* I hereby authorize Southern Orthopaedic Specialists to release any medical information necessary to process any insurance claim. I hereby authorize Southern Orthopaedic Specialists to release any medical information needed to administer Title XVIII (the Medicare program) of the Social Security Act. A photocopy of this authorization may be honored as valid. This authorization is valid until revoked by me in writing.

I understand that payment for services rendered is due at the time of the visit. If I fail to do this, I will be assessed a **$15 late fee.**

**X_____** **Date: _____**

**Patient's Signature** (self or parent or guardian for minor)

# Southern Orthopaedic Specialists

## HIPAA – Notice of Privacy Practice

The HIPAA notice is a 5-page explanation of the privacy act. This is a form explaining that Southern Orthopaedic Specialists will not release your information to anyone without your consent. If you would like a copy of the privacy notice, please ask the receptionist.

_____ I choose to receive a copy of this notice.

_____ I do not choose to receive a copy of this notice.

_____ _____

Signature Date