

# REGISTRATION RECORD

PATIENT'S NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT.: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M / F

MARITAL STATUS: S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_

PATIENT'S OCCUPATION: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S SS#: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

PHARMACY NAME & PHONE#: \_\_\_\_\_

**PRESENT COMPLAINT:** (Part of body involved) \_\_\_\_\_ (Right or Left) \_\_\_\_\_

Date of injury \_\_\_\_\_

Were you injured at work? Yes  No

Have you reported the injury to your employer? Yes  No

If yes, name of person to contact to verify: \_\_\_\_\_

Company Name and Address: \_\_\_\_\_

Was this an auto accident? Yes  No

Have you reported the accident to your motor vehicle insurance carrier? Yes  No

If yes, Name and Address of Motor Vehicle Insurance and Claim #: \_\_\_\_\_

FRIEND OR RELATIVE NOT LIVING WITH PATIENT	REFERRING PHYSICIAN / GENERAL CARE PRACTITIONER
NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
TELEPHONE#: _____	TELEPHONE#: _____
RELATIONSHIP: _____	

# INSURANCE INFORMATION

## HEALTH INSURANCE CARRIER

INSURANCE COMPANY #1: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

I.D.#: \_\_\_\_\_ GROUP OR PLAN #: \_\_\_\_\_ SUBSCRIBER'S DOB: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER'S SS#: \_\_\_\_\_

INSURANCE COMPANY #2: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP OR PLAN #: \_\_\_\_\_ SUBSCRIBER'S DOB: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER'S SS#: \_\_\_\_\_

## PERSON RESPONSIBLE FOR PAYMENT (must be filled in if responsible person is other than patient):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Name and Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

The person signing this Registration Form understands that he / she is ultimately responsible for payment of the medical services rendered by the physician(s). Should enforcement be necessary for the collection of the bill, attorney and collection fees as well as interest charges will be my responsibility.

I hereby authorize Somerset Orthopedic Associates to release all financial and medical information to my insurance companies and referring doctors.

\_\_\_\_\_  
SIGNED ( PATIENT OR PARENT OF MINOR )

\_\_\_\_\_  
DATE

I hereby assign payment directly to Somerset Orthopedic Associates, otherwise payable to me.

\_\_\_\_\_  
SIGNED ( INSURED PERSON )

\_\_\_\_\_  
DATE

**How would you like to pay for today's visit?**

CASH

CHECK

VISA

MASTERCARD

AMERICAN EXPRESS