Name:
DOB:
Chart:
Age/Gender:
Date:

SUBURBAN ORTHOPAEDICS

Please fill out completely

Patient Registration Form

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Cell Phone: ______ Email: ______

SS# ______ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race(please choose one): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined

Ethnicity(please choose one): ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Declined

Preferred Language: ______

Are you employed? ☐ Yes ☐ No ☐ Disabled ☐ Retired ☐ Other: ______

Employer: ______ Employer Phone: ______

Are you a student? ☐ Yes ☐ No Name of School: ______

Spouse's Name: ______ SS#: ______ Date of Birth: ______

Emergency Contact: ______ Phone: ______ Relation to Patient: ______

Preferred Pharmacy Information: Please fill out as much information as possible.

Pharmacy Name: ______ Pharmacy Phone Number: ______

Intersection or address if known: ______ City: ______ Zip Code: ______

If the patient is a minor under age 18, please list the responsible party.

Last Name: ______ First Name: ______ Relation to Patient: ______

Sex: ☐ Male ☐ Female SS#: ______ Date of Birth: ______

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Cell Phone: ______ Email: ______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ______

Are you employed? ☐ Yes ☐ No ☐ Disabled ☐ Retired ☐ Other: ______

Employer: ______ Employer Phone: ______

Medical Insurance Information

Primary Insurance Company: ______ Phone: ______

Claims Address: ______ City: ______ State: ______ Zip: ______

Subscriber ID / Policy Number: ______ Group Number: ______

Name of Policy Holder: ______ Policy Holders DOB: ______

Policy Holders SS #: ______ Insured Employer: ______

Secondary Insurance Company: ______ Phone: ______

Claims Address: ______ City: ______ State: ______ Zip: ______

Subscriber ID / Policy Number: ______ Group Number: ______

Name of Policy Holder: ______ Policy Holders DOB: ______

Policy Holders SS #: ______ Insured Employer: ______

Please Continue on the Next Page →

Name:
DOB:
Chart:
Age/Gender:
Date:

If you have any questions, or are not sure how to answer any of these questions, please do not hesitate to ask for help.

Question		
Is this visit related to an accident or injury?	☐ Yes	☐ No
Is this visit related to an accident, injury or otherwise, related to your workplace?	☐ Yes	☐ No
Is this visit related to an accident or injury at a school event?	☐ Yes	☐ No
Is this visit related to an auto accident or injury?	☐ Yes	☐ No
Is this visit related to an accident or injury other than auto, employment, or school event?	☐ Yes	☐ No

If yes, please describe: ______________________________

For Workers' Compensation Claims - Please complete the following:

Employer at time of injury: ______________________ Date of injury: __________

Address: ______________________ City: __________ State: ______ Zip: ______

Have you filed a claim with your employer: ☐ Yes ☐ No Employer Contact Person: __________

Name of Workers' Comp Insurance Co: ______________________ CLAIM #: __________

Insurance Address: ______________________ City: __________ State: ______ Zip: ______

Insurance Contact Person: __________ Phone: __________ Fax: __________

For Auto, or "Other" Insurance Claims - Please complete the following:

Date of Accident or Injury: ______________________ CLAIM #: __________

Auto or "Other" Insurance Company: ______________________ Phone: __________

Claims Address: ______________________ City: __________ State: ______ Zip: ______

Adjuster's Name: ______________________ Phone: __________

Legal Information

Attorney Name: ______________________ Phone: __________

Address: ______________________ Fax: __________

How did you hear about us?

☐ Physician (please complete below)
Name: _______________________________
Phone: ______________________________

☐ Family Member
☐ Friend
☐ Internet/Website
☐ High School

☐ Yellow Pages
☐ Advertisement
☐ Patient
☐ Location

Do you have a Primary Care Physician (PCP)? ☐ Yes ☐ No

Primary Care Physician: ______________________ Phone: __________

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to (Suburban Orthopaedics) Consultants. I authorize (Suburban Orthopaedics) Consultants to release any information, acquired in the course of my treatment, needed for my medical insurance claim(s). A photocopy of this authorization is to be considered valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or other third party payor is involved with payment. I understand that I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles. I understand that copays are expected at the time services are rendered. I certify that the above information is correct to the best of my knowledge.

Patient Signature: ______________________ Date: __________

Patient/Guardian Signature: ______________________ Date: __________