

**BONE & JOINT MEDICAL CENTER
PATIENT REGISTRATION**

PATIENT INFORMATION:

First Name, Middle, Last Name: _____

Address: _____

City/State/Zip: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Driver's License #: _____

SSN: _____ Date of Birth: _____ Sex: M F

E-mail Address: _____

Marital Status: Married Single Divorced Widowed

Pharmacy: _____

Referring Physician: _____

Family physician (if different than above): _____

Name of Nearest Relative: _____
(not residing in your home)

Phone Number of That Relative: _____

EMPLOYMENT INFORMATION: (PATIENT OR PARENT) CIRCLE ONE PLEASE

Name: _____ Employer: _____

Address: _____

Work Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____

Contract #: _____ Group #: _____

Insured Name & Date of Birth & SS#: _____

Their Employer: _____

Work Phone # _____

Employer's Address: _____

Secondary Insurance: _____

Contract #: _____ Group #: _____

Insured Name & Date of Birth & SS #: _____

Their Employer: _____

Work Phone # _____

Employer's Address: _____

CONSENT AND RELEASE

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

1. The patient or legal custodian authorizes the Staff Physician(s), Physician's Assistant(s), or Physical Therapist(s) to examine and treat the above patient;
2. Bone & Joint Medical Center is granted permission to release to the insurance carrier(s), employer(s), their representatives, referring physician, or physical therapist any information deemed necessary, and as may be requested, relating to any treatment rendered to patient, or on the patient's behalf;
3. Patient or legal custodian shall pay to Bone & Joint Medical Center such sums as are, or may become due, for services rendered to the patient. All co-pays and deductibles being due and payable at the time of service;
4. In the event that the patient's insurance company, employer, or school (as may be applicable) does not make full payment on this obligation, all balances will be due and immediately payable by the patient and/or legal custodian;
5. A returned check fee of \$25 will be assessed on any and all NSF checks;
6. Delinquent accounts will be assessed all collection, legal and administrative costs to the fullest extent of the law;
7. Patient authorizes payment of medical benefits to Bone & Joint Medical Center for Services rendered.

Signature: _____ Date: _____

PRIVACY PROTECTION NOTICE

I have received and do understand the "Notice of Privacy Protection" from Bone and Joint Medical Center, P.C.

_____ Date: _____

(Signature)