BAY STREET ORTHOPAEDICS PATIENT REGISTRATION FORM

NEW PATIENT___
ESTABLISHED PATIENT___

Appointment Date: ___________
Date Last Seen: ______________

Patient Name: ____Date of Birth: ________________

First M.I Last

Address: ____

Street PO Box City State Zip

Phone: ____ Email: ____________________________

Home Cell Work

Employed: Y N Occupation: ________________________ Student: Y N Retired: Y N

Employer Name: ______________________________________ Phone: __________________________________

In case of an emergency please contact:____

Name Phone Number

Body part to be seen:______________________________ Date of Injury/Onset: __________________

Who are we billing for today's services?

important for accurate billing

Insurance Carrier Name: ____

Is your injury work related: ☐ Yes ☐ No Is your injury auto related: ☐ Yes ☐ No

Primary Insurance Subscriber:____

Relationship:______________ Birth date:______________

Secondary Insurance Subscriber:____

Relationship:______________ Birth date:_____________

Social Security Number: ______________________________

If patient is a minor please complete the following

Parent/Legal Guardian:__________________________ Relationship:_____________ Birth date:__________

Address: (if different)____

Street PO Box City State Zip

Contact Numbers: Home:___________________ Cell:________________________ Work:______________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I AUTHORIZE THE PHYSICIANS OF BAY STREET ORTHOPEDICS TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT AND FURTHER AUTHORIZE PAYMENT OF BENEFITS DIRECT TO THE PHYSICIANS OF BAY STREET ORTHOPEDICS, OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THEIR SERVICES AS DESCRIBED HEREIN, I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE AFTER PAYMENT OF SUCH BENEFITS.

SIGNED:____ DATE: ______________________

Revised 1/24/2014