PATIENT REGISTRATION

Patient Name:_____**SSN**_____

Mailing Address:_____

Home Address:_____

Home Phone (_____)_____-_____ **Work Phone (____)_____-_____**

Cell Phone (_____)_____-_____

Date of Birth _____/_____/_____ **Sex: _____** **Marital Status: S M D W**

Employer Name: _____

Employer Address: _____
_____

EMERGENCY CONTACT:

Name:_____**Relationship:**_____
Home Phone:_____ **Alternate Phone:**_____
_____

POLICY HOLDER OF INSURANCE: (complete only if different from patient)

Policy Holder Name:_____**SSN**_____
Relationship to patient: Self [ ] Spouse [ ] Parent [ ] Policy Holder DOB_____/_____/_____
Policy Holder Address:_____
Policy Holder Phone #_____
Policy Holder Employer:_____
Employer Address:_____
_____

PRIMARY INSURANCE INFORMATION

Plan Name:_____
ID Number:_____ **Group Number:**_____
Policy Holder:_____**DOB**_____**SSN**_____

SECONDARY INSURANCE INFORMATION

Plan Name:_____
ID Number:_____ **Group Number:**_____
Policy Holder:_____**DOB**_____**SSN**_____
_____

I request payment of authorized Medicare or any other insurance benefits directly to Columbia Memorial Bone & Joint Center. I acknowledge that I am financially responsible for any unpaid balances, including services not covered by my insurance carrier.

I authorize the physician to release to Medicare or other insurance carriers any information needed to determine these benefits or benefits for related services.

I authorize Columbia Memorial Bone & Joint Center to use or disclose my health information to treat my condition, obtain payment for that treatment and run your business operations. You may also disclose my health information for payment activities and certain business operations of another health care provider or payor.

Signature:_____**Date:**_____
(Signature of Patient/Parent or Guardian)