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| --- |
| **Patient Registration** |
| **CURRENT PATIENT INFORMATION – PLEASE PRINT** | **Guarantor Information (to whom statements are sent)** |
| Last Name: |  | Name: |  |
| First Name: |  | Address: |  |
| Middle Name: |  |  |
| Address: |  | Relationship to patient: |  |
| City: |  | State: |  | Date of Birth: |  |
| Zip |  | Social Security No.: |  |
| Home Phone: |  | Phone: |  |
| Work Phone: |  | **Emergency Contact Information** |
| Mobile Phone: |  | Name: |  |
| Sex: |  | Relationship: |  |
| Date of Birth: |  | Phone: |  |
| Social Security No.: |  | Mobile Phone: |  |
| Patient email: |  |  |
| Required by government mandate[although you may refuse] | **Employer Information** |
| Language: |  | Employer: |  |
| Race: |  | Address: |  |
| Ethnicity: |  | Phone: |  |
| Marital Status: |  |  |
| **Other** | **Pharmacy Information** |
| Patient Referred by: |  | Name: |  |
|  |  |
| Primary Care Provider: |  | Crossroads: |  |
|  |  |
| Contact Preference: Home Phone/ Work Phone/ Mobile Phone/ Portal / Email | Phone: |  |
|  |
| **Primary Insurance Information** | **Secondary Insurance Information** |
| Insurance Plan Name: |  | Insurance Plan Name: |  |
| Last Name: |  | Last Name: |  |
| First Name: |  | First Name: |  |
| Middle Name: |  | Middle Name: |  |
| Address: |  | Address: |  |
| City: |  | State: |  | Zip: |  | City: |  | State: |  | Zip: |  |
| Date of Birth: |  | Date of Birth: |  |
| Employer Name: |  | Employer Name: |  |
| Patient’s relationship to policy holder: |  | Patient’s relationship to policy holder: |  |
|  |  |
| **Worker’s Comp or Motor Vehicle Accident Information** |
| Worker’s comp Plan Name: |  |
| Plan full Address: |  |
| Claim number: |  |
| Date of injury: |  |
|  |
| **To the best of my knowledge the above information is complete and accurate** |
|  |
| Signed: |  | Date: |  |

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|  |
| Patient Name (Please Print): |  |  |
|  |
| \*\*Please sign and date each item below\*\* |
|  |
| **ACKNOWLEDGEMENT AND AUTHORIZATION:** |
|  |
| * **I have read and understand the HIPAA/Privacy Policy for NORTHWEST ORTHOPAEDIC SPECIALISTS PS**
 |
|  |
|  |
| **Signed:** |  | **Date:** |  |
|  |
|  |
| * **I hereby assign my insurance benefits to be paid directly to the healthcare provider**
 |
|  |
|  |
| **Signed:** |  | **Date:** |  |
|  |
|  |
| * **I authorize NORTHWEST ORTHOPAEDIC SPECIALISTS PS to release medical information required to process my claim**
 |
|  |
|  |
| **Signed:** |  | **Date:** |  |
|  |
|  |
| * **I have read and understand the Financial Policy for NORTHWEST ORTHOPAEDIC SPECIALISTS PS**
 |
|  |
|  |
|  |
| **Signed:** |  | **Date:** |  |
|  |
| * **I authorize NORTHWEST ORTHOPAEDIC SPECIALISTS PS to obtain/have access to my medication history**
 |
|  |
|  |
| **Signed:** |  | **Date:** |  |
|  |
|  |
| * **I authorize my provider’s office to contact me by mobile phone**
 |
|  |
|  |
| **Signed:** |  | **Date:** |  |
|  |