|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | | |  | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| 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:** |  | |
|  | | | | | |