PATIENT REGISTRATION

Patient information *(please print)*

PATIENT'S LEGAL NAME *(last, first, middle)*	SOCIAL SECURITY #	GENDER ☐ M ☐ F	DATE OF BIRTH	AGE

ADDRESS	CITY / STATE / ZIP CODE	MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED

HOME PHONE #	CELL PHONE #	WORK PHONE #	EMAIL ADDRESS
( )	( )	( )	

EMPLOYER	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP CODE

PRIMARY CARE PHYSICIAN & PHONE #	REFERRING PHYSICIAN & PHONE #	ETHNICITY

Emergency contact

NAME *(last, first, middle)*	RELATIONSHIP	HOME PHONE #	CELL/WORK PHONE #
		( )	( )

Responsible Party *(complete this section only if someone other than the patient is financially responsible)*

RESPONSIBLE PARTY NAME *(last, first, middle)*	SOCIAL SECURITY #	GENDER ☐ M ☐ F	DATE OF BIRTH

ADDRESS	CITY / STATE / ZIP CODE	RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER

HOME PHONE #	CELL PHONE #	WORK PHONE #	OTHER PHONE #
( )	( )	( )	( )

EMPLOYER	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP CODE

Primary & secondary insurance

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #

GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE

SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #

GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE

Authorization for release of information
I authorize SPINE & ORTHOPEDIC SPECIALISTS to release any medical information necessary for purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services.

Assignment of benefits and financial responsibility
I authorize the assignment of benefits payable to SPINE & ORTHOPEDIC SPECIALISTS and/or its designee for physician services and supplies by government and/or other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services. I understand this office does not guarantee that my insurance company will pay for treatment I receive from this practice. They will perform routine insurance billing procedures upon verification of coverage. However, if my claim is denied, I will be responsible for paying the full amount at that time. This office will not enter into a dispute with my insurance company over any claim, although they will provide necessary documentation my insurance company requests to clarify any confusion or questions that may arise. This office will cooperate fully with the regulations and requests of my insurance company. I understand it is ultimately my responsibility to resolve any type of dispute over payments made or not made by my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company.

Authorization for additional fees
In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional costs that this action may incur.

Authorization for treatment
I agree to any examination, treatment, and/or procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

Acknowledgement of Receipt of Privacy Notice
By signing below I agree I that have received a copy of the **Notice of Privacy Practices for Protected Health Information.**

X_____|_____
SIGNATURE (Patient or Responsible Party) DATE