

PATIENT REGISTRATION

PATIENT NAME _____ DOB _____ AGE _____

HOME ADDRESS _____ HOME NUMBER _____

CITY / STATE / ZIP _____ WORK NUMBER _____

EMPLOYER _____ JOB TITLE _____ CELL NUMBER _____

EMPLOYER ADDRESS _____

NAME OF SPOUSE OR PARENT _____ HOME NUMBER _____

ADDRESS (IF DIFFERENT) _____ WORK NUMBER _____

SEX M F MARITAL STATUS MARRIED SINGLE DIVORCED WIDOW(ER)

PRIMARY DOCTOR _____ REFERRING DOCTOR _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

INSURANCE CARDHOLDER NAME _____ RELATIONSHIP TO PATIENT _____

HOME ADDRESS (IF DIFFERENT) _____ CITY / STATE / ZIP _____

DOB OF INSURED _____ HOME NUMBER _____ OTHER NUMBER _____

WHEN WAS THE MOST RECENT ONSET OF PAIN?

(If pain started less than 6 months ago please list the approx date of onset;
if pain started more than 6 months ago, please list the approximate date that it
began hurting again – enough to make you want to seek medical attention for it again)

_____ / _____ / _____

PLEASE READ AND INITIAL ALL THREE OF THE FOLLOWING STATEMENTS

The information on these forms is accurate to the best of my knowledge. (INITIAL) _____

I have received, read and understand the HIPAA PRIVACY POLICY. (INITIAL) _____

I hereby authorize Fairfax Orthopaedics to apply for benefits on my behalf for services covered by my insurance carrier and request that all payments are made directly to my attending physician. I accept financial responsibility for all non-covered services. Either the insurance carrier or I may revoke this authorization at any time in writing. (INITIAL) _____

SIGNATURE (SUBSCRIBER, BENEFICIARY OR PARENT OF MINOR CHILD)

DATE