Fairfax Orthopaedics, PLLC

PATIENT REGISTRATION

PATIENT NAME ____ Date of Birth____________ 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 ____________________________

Name of Policy holder ______________________ Relationship to patient ____________ DOB of policy holder _______

WHEN WAS THE MOST RECENT ONSET OF PAIN?

________/_______/_______

PLEASE READ AND INITIAL ALL FOUR OF THE FOLLOWING STATEMENTS:

The information on these forms is accurate to the best of my knowledge**. INITIAL _________________**

I have received or have been advised that the full notice of privacy practices is available upon request. **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. I may revoke this authorization at any time in writing. **INITIAL ___________**

I give permission for Fairfax Orthopaedics to share my medical information with my primary care doctor. **INITIAL______**

Signature ____ Date __________________________

(Patient or parent of minor child)