PERFORMANCE ORTHOPEDICS
Faster, Higher, Stronger

PATIENT REGISTRATION FORM
(Please print all information below)

Today's Date: _____

Patient Full Name: _____ Gender: ( ) Male ( ) Female

Patient Mailing Address: _____ City: _____ Zip Code: _____

Date of Birth: _____ Best Phone: _____-_____ 2nd Phone: _____-_____

Email Address: _____

Primary Care Physician: _____ Referring Physician (if different): _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Spouse's Name: _____

Race: ( ) American Indian ( ) Asian ( ) Black ( ) Native Hawaiian ( ) White ( ) Other: _____

Ethnicity: ( ) Hispanic Origin ( ) Non-Hispanic ( ) Other: _____

If patient is under 18 years of age, please complete the following:

Parent or Guardian Name: _____ SS#: _____

Phone (if different from above): _____

Address (if different from above): _____

Emergency Contact Information

Name: _____ Relationship to patient: _____

Cell Phone: _____-_____ Home Phone: _____-_____ Work Phone: _____-_____

Primary Insurance Information

Insurance Company Name: _____

Policy ID# _____ Group # _____

Effective Date of Coverage: _____ Policy Holder Name: _____

Date of Birth: _____ Social Security Number: _____

Patient's Relationship to Policy Holder: ( ) Self ( ) Spouse ( ) Child ( ) Other: _____

Secondary Insurance Information

Insurance Company Name: _____

Policy ID# _____ Group # _____

Effective Date of Coverage: _____ Policy Holder Name: _____

Date of Birth: _____ Social Security Number: _____

Patient's Relationship to Policy Holder: ( ) Self ( ) Spouse ( ) Child ( ) Other: _____

Authorization:

I hereby authorize the submission of insurance claims along with the medical records necessary to obtain payment from my insurance company(s). I hereby authorize payment of insurance benefits to be made to Performance Orthopedics for services provided to me or members of my family. I understand that I am fully financially responsible for all charges not covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I agree to release pertinent demographic and insurance information to a specialist and/or health services provider in the event that it is necessary in my course of treatment.

I acknowledge that I have reviwed/received this office's notice of privacy practices, which explains how my medical information will be used and disclosed.

I certify the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under general or specific instructions of the physician.

_____ _____

Patient Signature **Date**

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