



SPECIALTY ORTHOPEDICS

I-CARE

Patient Registration Form

(Please Print - Fill In All Blanks)

Patient Information

Name: _____ Soc. Sec. Number: _____
Last name First Name Initial

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Pager #: _____ How did you find us? _____

Sex: M F Age: _____ Birthdate: _____ Email: _____

Who is your family physician? _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone Number: _____ Extension #: _____

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name: _____ Spouse's Soc. Sec. Number: _____

Spouse's Birthday: _____ Spouse's Employer: _____

Spouse's Work Phone: _____ Extension #: _____

Who Shall we contact in an emergency?: _____

Relationship: _____ Phone number: _____

Primary Insurance Information

Who is responsible for this bill? _____
Last Name First Name M.I.

Relationship to patient: _____ Soc. Sec. #: _____

Address (if different from patients): _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Company Name: _____

Policy #: _____ Group #: _____ Subscriber#: _____

Additional Insurance Information

Who is responsible for this bill? _____
Last Name First Name M.I.

Relationship to patient: _____ Soc. Sec. #: _____

Address (if different from patients): _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Company Name: _____

Policy #: _____ Group #: _____ Subscriber#: _____

Authorization to Pay Benefits to Physician and to Release Information: I hereby authorize payment directly to the physicians of the surgical and/or medical benefits, if any, otherwise payable to me for their services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims. I authorize the use of this signature on all insurance forms and submissions.

Signature: _____ Date: _____

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, drugs and other services and supplies as are considered necessary of beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

Initials: _____

Release of medical information and authorization to pay insurance benefits: I authorize my physician to release information from my medial record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initials: _____

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries of carriers, or to the Professional Standards Review Organizations for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

Initials: _____

Financial Agreement: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patients responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initials: _____

Patient's Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Do you have an Advanced Directive (Living Will)? _____