PATIENT REGISTRATION

TODAY'S DATE: _____ FAMILY PHYSICIAN: _____

PATIENT NAME: _____ _____ _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

HOME PH#: _____ CELL PH#: _____ DATE OF BIRTH: _____/_____/_____

SOCIAL SECURITY#: _____ Sex: M F Marital Status: _____

YOUR EMPLOYER: _____
OCCUPATION: _____ ☐ FULL TIME ☐ PART TIME
EMPLOYER'S ADDRESS: _____ WORK PH: _____
SPOUSE'S NAME: _____
SPOUSE'S EMPLOYER: _____ ADDRESS: _____

RESPONSIBLE PARTY FOR BILLING

("SELF" if consistent with information above)

NAME _____ SS # _____ DOB: _____/_____/_____
COMPLETE ADDRESS
_____
PHONE: _____ EMPLOYER: _____

FRIEND/RELATIVE WHOM WE CAN CONTACT IN THE EVENT OF EMERGENCY:
Name: _____ Ph# : _____
Address: _____

Who Referred You To Our Office?
☐ Dr. _____ ☐ Hospital _____
☐ Employer _____ ☐ Other _____

INSURANCE INFORMATION

☐ PRIMARY INSURANCE: _____
Subscriber ID #: _____ Group #: _____
Subscriber Name: _____ D.O.B. _____
Effective Date: _____ Address: _____

☐ SECONDARY INSURANCE: _____
Subscriber ID #: _____ Group #: _____
Subscriber Name: _____ D.O.B. _____
Effective Date: _____ Address: _____

☐ No Fault (Motor Vehicle Accident) Date of Accident: _____ Location: _____
Insurance Company: _____ CLAIM#: _____
Address: _____ Policy Holder's Name _____
Policy #: _____

☐ Workers' Compensation Date of Injury: _____ Area of Injury: (Body part) _____
Insurance Carrier: _____ Claim #: _____
Carrier Address: _____
Phone# : _____ Worker's Comp Board # (WCB): _____
Attorney's Name & Address: _____
Have you had X-Rays? _____ If Yes, Where/When were they done? _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. ASSIGNMENT OF BENEFITS: I, the undersigned, hereby authorize payment of medical and surgical benefits directly to CNY Orthopedic Sports Medicine, P.C.

SIGNATURE _____ for _____ Date _____