PATIENT REGISTRATION AND CONSENT FOR TREATMENT FORM

LAST NAME	**FIRST NAME**	**MIDDLE NAME**
SEX **____Male ____Female**	**SOCIAL SECURITY #**	**NAME OF SPOUSE**
PERSON RESPONSIBLE FOR BILL □ Self **□ Other _____**	**MARITAL STATUS** **__SINGLE __MARRIED** **__ WIDOW ___DIVORCED**	**REFERRING MD NAME:** **CITY STATE**
DATE OF BIRTH	**CUSTODIAL GUARDIAN** *(if pt. is a minor, if applicable provide copy of custodial papers)*	

MAILING ADDRESS Street_____

City _____State_____ Zip_____

FAMILY DR. _____

PATIENT PHONE NUMBERS

HOME _____

WORK_____

CELL_____

EMERGENCY INFORMATION

CONTACT NAME_____

RELATION TO PATIENT_____

STREET_____

CITY _____ State _____ ZIP_____

HOME PHONE_____ WORK _____

EMPLOYER INFORMATION

Name _____ Pt. occupation_____

Street or PO Box_____

City _____State_____Zip_____

Phone number_____

INSURANCE INFORMATION (Primary) Workers' Compensation claim □ yes □No

Subscriber Name_____SS#_____

Relation to patient_____ Birth date_____

Insurance Company_____Phone_____

Please show insurance card to the registration staff so that they can get additional information

INSURANCE INFORMATION (Secondary)

Subscriber Name_____SS#_____

Relations to patient_____ Birth date_____

Insurance Company_____Phone_____

Please show insurance card to the registration staff so that they can get additional information

Please read the attached office policies. A copy of these policies will be given to you upon request.

By signing below I indicate that I have read, understand and agree to the conditions noted in the office policies of Norton Orthopaedic & Sports Medicine Specialists.

Signature: _____Date: _____

I authorize the release of medical information necessary to process my medical claims. I authorize payment from my insurance company to be made directly to the facility. I understand that I am responsible for, and agree to pay any and all expenses not covered by my insurance or which are not paid by the insurance company in a reasonable and timely manner. My signature also serves as consent for medical treatment.

Signature: _____Relationship:_____Date:_____

We affirm our commitment to comply with federal and state requirements pertaining to the use and disclosure of your protected health information. A copy of our privacy policy will be given to you upon request. ***Optional:*** Additionally I give Norton Orthopaedic Specialist permission to give medical information to:_____

Signature: _____Date: _____