



PATIENT REGISTRATION

Please Print

Date _____

Patient Name _____ Age _____ Birth Date _____ Sex _____
Last First M

If patient is a minor, lives with _____ Relationship _____

Address _____ City & State _____ Zip _____

Home Phone _____ Alternate Phone _____ Cell Phone _____

Email Address _____ Patient's Social Security # _____

Marital Status: Single Married Divorced Widowed Separated

Occupation _____

Employer Name & Address _____

Employers Phone _____

Parents/Spouse _____ Spouse's Employer _____

Parents/Spouse's D.O.B. & SS # _____ Primary Physician _____

Referred By _____ Pharmacy _____

RESPONSIBLE PARTY—IF OTHER THAN THE PATIENT, PLEASE COMPLETE

Name _____ Relationship to patient _____

Address _____ City & State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Employer Name & Address _____ Date of Birth _____

NEAREST FRIEND OR RELATIVE NOT LIVING WITH THE PATIENT

Name _____ Relationship to patient _____

Address _____ Phone _____

MEDICAL INSURANCE INFORMATION

Do you have Medicare? yes _____ no _____ Part A _____ Part B _____ You must have your card at time of visit.

Primary Insurance Company

Secondary Insurance Company

	<i>Primary Insurance Company</i>	<i>Secondary Insurance Company</i>
Insurance Carrier		
Policy Holder Employer		
Policy Holder (Name on Card)		
Relationship to patient		
Policy Holder birth date		
ID#		
Group#		

(continued on next page)

ACCIDENT / INJURY

Is your visit today related to an accident? No Yes

If Yes, what type? Work related Auto Accident Other _____

Date of accident _____ Place of accident _____

Time of accident _____ Side of Body _____

How did your accident occur? _____

Name of any physician who treated you at time of accident _____

Contact Person at your Employer _____ Phone _____

CONSENT OF TREATMENT, RELEASE OF INFORMATION AND PAYMENT OF BILL AGREEMENT

I hereby permit the doctors and clinical staff of West Kentucky Orthopaedics and Sports Medicine to provide treatment to me. I authorize West Kentucky Orthopaedics and Sports Medicine to furnish medical and related information to insurance carriers concerning my dependent or myself. I hereby assign to West Kentucky Orthopaedics and Sports Medicine all insurance payments for medical services rendered to myself or my dependents. I also acknowledge that I am directly responsible for payment of amount of all bills for services by West Kentucky Orthopaedics and Sports Medicine regardless of any insurance coverage I may have. I understand and agree that I am responsible for paying any co-pay amount, deductible and/or any non-covered services at the time of service. I understand that if I am uninsured, payment is required before services will be rendered. If for any reason any portion of the account for which I am responsible should become delinquent, I agree to pay for all collection and legal fees, including attorneys' fees.

Signature of Patient or Responsible Party

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to West Kentucky Orthopaedics and Sports Medicine, for any services furnished me by that physician. I authorize West Kentucky Orthopaedics and Sports Medicine and any employee acting on behalf of the West Kentucky Orthopaedics and Sports Medicine to release to the Health Care Financing Administration and its agents any medical and related information about me needed to determine these benefits or the benefits payable for related services.

Signature

Date

PATIENT AUTHORIZATION

Initial I authorize the release of all medical records maintained by West Kentucky Orthopaedics and Sports Medicine. These records may be released as needed for my care, for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and/or third party liability claim.

Initial I authorize direct payment of benefits from my insurance plan to West Kentucky Orthopaedics and Sports Medicine. I understand that I am responsible for payment of professional fees charged by West Kentucky Orthopaedics and Sports Medicine which are not covered, or not properly reimbursed, under the terms of my insurance plan.

Initial I will provide West Kentucky Orthopaedics and Sports Medicine with the phone numbers I authorize West Kentucky Orthopaedics and Sports Medicine to use to contact me. I authorize the use of any messaging person or system, voice mail and/or an answering machine to convey information regarding my care.

Initial I authorize the use of Faxing or Email to send my information to myself or to other authorized parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when Faxing or Email is used.

Initial I understand that it is my right to request limited access to my records and to withdraw permission for the release of my records. I understand that if I make this request it must be in writing and that limiting or withdrawing my permission may result in West Kentucky Orthopaedics and Sports Medicine discontinuing its relationship with me and that I will need to seek care from another source.

Initial I have received a copy of West Kentucky Orthopaedics and Sports Medicine Notice of Privacy Practices for Protected Health Information.

Signature of Patient or Responsible Party

Witness

Date