

BOULDER ORTHOPEDICS

Registration Form

TODAY'S DATE: _____

Please provide the receptionist with your insurance card and picture id

PATIENT INFORMATION (ALL FIELDS ARE REQUIRED)

CONFIDENTIAL

Have you or any member of your family been a patient here before? Yes [] No []

PATIENT: _____ AGE: _____ BIRTHDATE: _____
[LAST NAME] [FIRST NAME \ LEGAL] [MIDDLE INITIAL / NICKNAME] MONTH / DAY / YEAR

Address: _____
[PERMANENT STREET ADDRESS] [CITY] [STATE] [ZIP CODE]

Home Phone: (____) _____ Cell Phone: (____) _____ Business Phone (____) _____
BEST NUMBER TO REACH ME AT : Y N BEST NUMBER TO REACH ME AT : Y N BEST NUMBER TO REACH ME AT : Y N

E-mail Address: _____ Would you like to receive our newsletters? Yes [] No []

Marital Status: Married Single Divorced Widowed Sex: M [] F [] Spouse's Full Name: _____

Please CIRCLE

Social Security No: _____ - _____ - _____ Patient's Occupation: _____
PATIENT'S ***** CONFIDENTIAL MANDATORY INFORMATION *****

Employed by: _____ Retired? Yes [] No []

Employment Address: _____
PATIENT'S [STREET] [CITY] [STATE] [ZIP CODE]

PERSON RESPONSIBLE FOR PAYMENT (if patient, write same/ if spouse is primary card holder use this same for spouse info)

NAME: _____ Relationship to Patient: _____
[LAST NAME] [FIRST NAME \ LEGAL] [MIDDLE INITIAL]

Address: _____
[STREET ADDRESS] [CITY] [STATE] [ZIP CODE]

Home Phone: (____) _____ Cell Phone: (____) _____ Business Phone (____) _____

Social Security No: _____ - _____ - _____ BIRTHDATE: _____
***** CONFIDENTIAL MANDATORY INFORMATION ***** Guarantor's MONTH / DAY / YEAR

Employed by: _____ Occupation: _____ Retired? Yes [] No []

Employment Address: _____
[STREET] [CITY] [STATE] [ZIP CODE]

REFERRAL

How did you hear about our practice? _____

Who may we thank for referring you to our office? _____

Primary Care Physician's Name & Address: _____

IN CASE OF EMERGENCY (Friend or Relative NOT living with you)

Name: _____ Relationship: _____ Phone: (____) _____
FIRST & LAST

Address: _____
[STREET ADDRESS] [CITY] [STATE] [ZIP CODE]

INJURY INFORMATION (Required information for your treatment and insurance company)

Is this an accident? Yes [] No []* Date of Accident ____/____/____ or *Date of Symptoms: ____/____/____
Month Day Year Month Day Year

What was injured? Rt. Knee [] Lt. Knee [] Rt. Shoulder [] Lt. Shoulder [] Other** [] _____

** Please describe injury: _____
Body Part and Symptoms

Work Related [] * (if so please complete appropriate data on separate form- see receptionist) Auto Accident [] Ski Injury []

Please describe how injury occurred: _____
How did this happen

***Please fill out all information on the back of this form

Insurance:

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is NOT a substitute for payment. Many companies have fixed allowances or percentages based upon your contract with them, NOT with our office. It is your responsibility to pay your deductibles, co-insurance and co-pays. We will do all we can to assist you in receiving reimbursement, but YOU are responsible for your bill. Unpaid patient balances will be collected prior to all patient appointments.

Primary Insurance Company's Name: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

POLICY #: _____ **GROUP #:** _____

Name of Policy Holder: _____ Relationship to Patient: _____
[LAST NAME] [FIRST NAME \ LEGAL] [MI] *If patient write SAME"

Home Address: _____ City: _____ State: _____ Zip: _____
POLICY HOLDER

Phone: (____) _____ SS # _____ - _____ - _____ Sex: M [] F [] Date of Birth: _____
***** CONFIDENTIAL MANDATORY INFORMATION ***** MONTH / DAY / YEAR

Employer: _____ Occupation: _____

Is this a COBRA Policy? Yes [] No []

Secondary Insurance Company: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

POLICY #: _____ **GROUP #:** _____

Name of Policy Holder: _____ Relationship to Patient: _____
[LAST NAME] [FIRST NAME \ LEGAL] [MI] *If patient write SAME"

Home Address: _____ City: _____ State: _____ Zip: _____
POLICY HOLDER

Phone: (____) _____ SS # _____ - _____ - _____ Sex: M [] F [] Date of Birth: _____
***** CONFIDENTIAL MANDATORY INFORMATION ***** MONTH / DAY / YEAR

Employer: _____ Occupation: _____

Workman's Compensation: Does WC cover this visit? Yes [] No [] *If yes see receptionist for a separate form

Auto Accident: Please note that Auto Insurance has limits and your primary insurance information is required.

Is this an Auto Claim? Yes [] No [] Date of Auto Injury: ____/____/____
MONTH / DAY / YEAR

Auto Insurance: _____ Phone: (____) _____ Claim # _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Claims Adjuster's Name: _____ Claims Adjusters Phone: (____) _____ ext: _____
FIRST & LAST

Claims Adjusters Fax #: (____) _____

Assignment of Benefits:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered valid as the original.

I UNDERSTAND THAT I AM FINANCALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND THE FINANCIAL POLICY AND I UNDERSTAND IT.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____