



Patient Registration

Please print clearly and complete all information

Date: _____

Patient Information (Please Print)

Name:	Sex:	Birthdate:	Age:
Street Address:	City:	State:	Zip:
Mailing Address: (if different)	City:	State:	Zip:
Social Security #:	Marital Status: ___ Married ___ Single ___ Separated		
Home Phone: ()	Cell Phone: ()		
E-mail address:			
I would prefer to receive appointment reminders by: <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Text <input type="checkbox"/> E-mail			
Occupation:	Employer:		

Person Responsible for Payment (if different from patient, worker's comp, or patient is a minor)

Name:	Relationship to Patient:
Street Address:	Social Security #:
City: State: Zip:	Employer:
Home Phone: ()	Address:
Cell Phone: ()	City: State: Zip:

Emergency Contact:

Name:	Relationship to Patient:
Street Address:	Home Phone: ()
City: State: Zip:	Cell Phone: ()

Referring Information: (How did you learn about us?)

Referring Doctor:	Primary Care Doctor:
City: State:	City: State:
Other: (Circle choice) Insurance Co. Yellow Pages Friend/Family Newspaper Ad Other: _____	

Primary Insurance Company:

Company Name:
Claims Address:
City: State: Zip:
Policy Holder: Name:
Sex: Birthdate:
Policy Holder's ID:
Group #:
Policy Holder's Social Security #:
Patient's relationship (circle): Self Spouse Child Other

Secondary Insurance Company

Company Name:
Claims Address:
City: State: Zip:
Policy Holder: Name:
Sex: Birthdate:
Policy Holder's ID:
Group #:
Policy Holder's Social Security #:
Patient's relationship (circle): Self Spouse Child Other

Information the Government Requires Us to Request:

Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline to State
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to State
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to State

Authorization to Release Information

Authorization to Receive Insurance Payment

Acknowledgement of Financial Responsibility

I hereby authorize The Orthopaedic and Sports Medicine Center of Camden, P.C. (“Felix Orthopaedics”) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the practice and direct my insurance carrier or its intermediaries to issue payment directly to Felix Orthopaedics. I also authorize Felix Orthopaedics to release any information regarding my claim to my insurance company or to my employer (if work related). I understand that I am financially responsible to the practice for any co-pays, deductible and co-insurance required by Medicare or by my insurer, and for any balance not covered by Medicare or other insurance. If I am not covered by insurance, or if any part of the charges for services provided to me are not paid to Felix Orthopaedics by my insurance, I promise to promptly pay those charges unless I make other arrangements (a payment plan) with the practice. I understand that if my insurance plan requires a referral and this has not been obtained, I am responsible for payment for services rendered. I promise to pay any outstanding balances due related to the services furnished to me by Felix Orthopaedics within 30 days, or according to the terms of a written payment plan with Felix Orthopaedics, and agree that failure to do so may result in collection action. I agree to pay any and all collection and legal fees and costs related to collection of my unpaid balance. A photocopy of this authorization shall be as valid as the original.

Patient or Authorized Representative Signature

Date

Medicare Patients Only: Statement to Permit Payment of Medicare Benefits to Provider and Patient

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Felix Orthopaedics. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient or Authorized Representative Signature

Date

Consent to Treatment

I hereby consent to and authorize Felix Orthopaedics to administer such diagnostic procedures and/or treatment or both as may be advisable to evaluate and treat my injury or illness. I further understand that I have the right to refuse any suggested examination, test or treatment.

Patient or Authorized Representative Signature

Date

Notice of Privacy Policy

I acknowledge that I have received the “Notice of Privacy Policy” from Felix Orthopaedics. I authorize Felix Orthopaedics to release any requested information about my medical condition and care to any of the following persons who may request it:

Names of persons to whom information may be released

Patient or Authorized Representative Signature

Date