BENTON FRANKLIN ORTHOPEDIC ASSOCIATES

REGISTRATION FORM

(Please Print)

OFFICE USE ONLY: Account#:_____

Date:_____By:_____

PATIENT INFORMATION

Patient's First Name: MI: Last:			Nickname:
Date of Birth:	Patient Street Address:		Patient Street Address 2:
City:	State:	Zip:	Country:
Home Phone: ( )	Daytime: ( )	Mobile: ( )	Social Security Number:

Sex: ☐ M ☐ F **Marital Status**: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Email Address:	Employer/School:	Employer/School Phone:
Referring Doctor:	Primary Care Provider:	

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic / Latino ☐ Decline to answer

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ Pacific Islander ☐ White ☐ Decline to answer

Language: ☐ English ☐ Spanish ☐ Russian ☐ Arabic ☐ Somali ☐ Other

Selected our office the first time because / Referred to office by (check all that apply): emergency room: (☐ KGH ☐ Lourdes ☐ Kadlec)

urgent care center: (☐ KGH ☐ Lourdes Kania ☐ Physician's Immediate Care ☐ Kadlec Urgent Care)

☐ television ☐ newspaper ad ☐ yellow pages ☐ internet search

☐ health care provider _____ ☐ family member / friend _____

☐ other (explain) _____

IN CASE OF EMERGENCY

Name of friend or relative not living at same address:	Relationship to Patient:	Cell/Home Phone:	Work Phone:

ORTHOPEDIC PROBLEM

Orthopedic Problem: side: ☐ left ☐right	How did injury occur? :	Date of Injury:
Where did injury occur? : ☐ home ☐ auto ☐ work ☐ other	On the Job? ☐ yes ☐ no	Reported (if on job): ☐ yes ☐ no
Employer at Time of Accident:	Claim Number:	

BILLING INFORMATION (fill out if person responsible for bill is different than patient)

First Name (guarantor): MI: Last:		Relationship to Patient:	Social Security No.:
Billing Address (if different than above):	City:	State	Zip:
Employer:	Cell Phone:	Work Phone:	Birthdate:

PRIMARY INSURANCE INFORMATION

Insurance Company:	Subscriber Name:	Birthdate:
Subscriber Employer:	ID#:	Group#:

SECONDARY INSURANCE INFORMATION

Insurance Company:	Subscriber Name:	Birthdate:
Subscriber Employer:	ID#:	Group#:

+CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I understand and have been provided with a Notice of Privacy Practices that provides a description of information uses and disclosure. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. The organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Organization has already taken action in reliance thereon.

+BILLING AUTHORIZATION: I request payment of authorized Medicare or Insurance benefits be made to my physician on my behalf for any services furnished me by this medical staff. I authorize any holder of medical information about me to release to HCFA and its agents or to my other insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. **I accept financial responsibility for non-covered services.**

Signature_____ Date_____