

PATIENT REGISTRATION INFORMATION			
Name, (Last, First, Middle) <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Dr			Social Security Number
Parent/Guardian		Home Phone: _____ Cell Phone: _____	Work Phone: _____
Address		City _____ State _____ Zip _____	
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Age _____
Place of Employment		Work Address _____	
In emergency, contact:		Relationship _____	Phone _____
REASON FOR VISIT			Date of Onset _____
Name of Referring Doctor		WC <input type="checkbox"/>	MVA <input type="checkbox"/>
		Other <input type="checkbox"/>	
HEALTH INSURANCE INFORMATION			
PRIMARY INSURANCE CARRIER'S NAME			
Insurance Carrier's Address		City _____ State _____ Zip _____	
Name of Insured		Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Insured's Phone _____
ID #		Group # _____	
SECONDARY INSURANCE			ID# _____
LAWYER'S NAME (If applicable, e.g. accident)			Lawyer's Phone _____
Lawyer's Address		City _____ State _____ Zip _____	
When you engage the services of an attorney, you <u>must notify</u> this office immediately.			

AGREEMENT	
<p><i>In consideration of the examination to be provided by South Palm Orthopedics: I understand that the doctor makes no representations about my condition other than those concerning the problem for which he has been retained. I hereby authorize South Palm Orthopedics (SPO) to furnish information to insurance carriers regarding illness and treatments to me and/or my dependants and to obtain a release of medical information in writing, by e-mail, fax, or through electronic assignment to the appropriate parties as needed. I authorize release of all information necessary to secure payment. I hereby assign to SPO any/all benefits/payments received from my insurer, including any personal injury protection coverage, received as a result of a liability settlement. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment and of this signature is to be considered valid. I agree to pay any deductible or other balance not paid by my insurer.</i></p> <p>I am responsible for payment in full for all fees regardless of insurance reimbursement. Payment is required after each visit for medical services unless other payment arrangements are made. I understand that a monthly charge of 1.5% (ANNUAL RATE 18%) and collection costs including attorney's fees, if applicable, may be charged on overdue payments. It is our policy that patients who are younger than 18 years of age must be accompanied by their parent/guardian.</p>	
_____ PATIENT'S SIGNATURE	_____ DATE