ASHEVILLE ORTHOPAEDIC ASSOCIATES

setting the pace of orthopaedic care

REGISTRATION FORM

TODAY'S DATE: ACCOUNT #:

FIRST NAME: **MI:** **LAST NAME:** **SSN:**

DOB: **AGE:** **MARITAL STATUS:** **SEX:**

ADDRESS: **ZIP:** **CITY:** **STATE:**

PRIMARY PHONE (number you wish to be reached at): **OTHER #:** _____

E-MAIL: _____

OCCUPATION: _____ **WORK No:** **EMPLOYER:**

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled

STUDENT STATUS: ☐ Full Time ☐ Part Time ☐ Not a Student

RACE: _____ **ETHNICITY:** _____ **PREFERRED LANGUAGE:** _____

In Case of **EMERGENCY**, Notify:
Name: _____ Relationship: _____ Phone No: _____

If Patient is a Minor, please provide name of Parent or Legal Guardian:
Name: _____ Relationship to Patient: _____

Is This an Injury? ☐ Yes ☐ No Liability Insurance: _____
Is this Work Related? ☐ Yes ☐ NO Date of Injury: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____
Address: _____ City: _____ State: _____

Who Referred You To Our Office?
REFFERING PHYSICIAN'S NAME: _____ Phone: _____
Address: _____ City: _____ State: _____

☐ FAMILY

☐ FRIEND

☐ INSURANCE COMPANY ☐ PHONE BOOK ☐ PATIENT PORTAL ☐ WEB SITE

Insurance Information

PRIMARY INSURANCE: _____ **INSURED'S NAME:** _____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

POLICY #: _____ **GROUP #:** _____
Policy Holder's DOB: _____ SSN: _____ Employer: _____

SECONDARY INSURANCE:_____ **INSURED'S NAME:** _____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

POLICY #: _____ **GROUP #:** _____
Policy Holder's DOB: _____ SSN: _____ Employer: _____

Appt Date: Appt Time: Provider:
Appt Reason: -

ASHEVILLE ORTHOPAEDIC ASSOCIATES, P.A.

Patient Name: _____ **DOB:** _____ **Account #:** _____

AUTHORIZATION

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Asheville Orthopaedic Associates. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Asheville Orthopaedic Associates, P.A. to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_____ Date _____

Are you the Guarantor? Yes__ No __ If not please see receptionist.

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) to Asheville Orthopaedic Associates, P.A., I acknowledge recognition of the fact that the evaluation and treatment received from Asheville Orthopaedic Associates, P.A. is advised and deemed necessary to be the judgment of the Physician.

X Signature_____ Date _____

CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

As a patient I agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Asheville Orthopaedic Associates, P.A. to disclose my personal medical information to the following individual(s).

____Asheville Orthopaedic Associates, P.A. may disclose my medical information only in my presence.

____Asheville Orthopaedic Associates, P.A. may disclose my medical information when I am not present; this includes telephone calls, fax or mail.

____I understand that this consent may be revoked by me at anytime by written notice of Asheville Orthopaedic Associates.

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

_____ **Person(s) listed above age 18 or older may pick up prescription when I am not present.**

X Signature_____ Date _____