Shoreline Orthopaedics

Patient Registration Form

Demographic Information: For Patient **ONLY**. Parent/legal guardian please also complete the back of this form

Legal Name:		SSN:	Gender:	Date of Birth:
Address:		City/State/Zip		
Employer:	Primary Phone Number:	Alternate Phone Number:	Can confidential messages (such as appointment reminders) be left on a voicemail/answering machine? ☐ Yes ☐ No	
E-mail:				

Primary Care Physician: _____ Referring Physician: _____

Authorized Contacts:

I hereby authorize release to the following person(s) of my Protected Health Information (PHI). Please check the box on the right if we may contact this person in the event of an emergency only. For all others, leave blank.			Emergency only?
Name:	Relationship to Patient:	Contact Number:	
Name:	Relationship to Patient:	Contact Number:	
Name:	Relationship to Patient:	Contact Number:	

Insurance/Financial Information:

Primary Insurance Company:		Secondary Insurance Company:	
Insured Name:	Date of Birth:	Insured Name:	Date of Birth:
Relationship to Patient:	SSN:	Relationship to Patient:	SSN:

Is your injury related to a Workers' Compensation claim? ☐ Yes ☐ No Date of Injury: _____

Is your injury related to an Auto Insurance claim? ☐ Yes ☐ No Date of Injury: _____

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the physician or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original. I agree to the posted financial policy in its entirety. (Copies available upon request or on www.shorelineortho.com)

Medicare:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Shoreline Orthopaedics for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

Acknowledgement of HIPAA Privacy Policy

I acknowledge that Shoreline Orthopaedics' "Notice of Privacy Practices" has been offered and/or provided to me. (Copies posted at the office, available upon request, or online at www.shorelineortho.com). I understand that Shoreline Orthopaedics reserves the right to change this notice at any time, without warning, and will post a copy of the revised notice in the waiting areas of the office.

By signing this form, I am consenting to Shoreline Orthopaedics' use and disclosure of my PHI to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this request, Shoreline Orthopaedics may decline to provide treatment to me.

Patient/Legal Representation Signature: _____ Date: _____

For Minors (Patients under age 18): To be completed by a Parent/Legal Guardian

Patient Information:

Name:	Date of Birth:

Parent Information:

Father	Mother
Name: _____ Address (If different than patient): _____ _____	Name: _____ Address (If different than patient): _____ _____
Primary Contact number: ( )	Primary contact number: ( )
Date of Birth:	Date of Birth:
SSN:	SSN:
Employer:	Employer:

Consent for treatment of a minor:

Person(s) listed below have permission from _____, parent/legal guardian of

(Printed name of parent/legal guardian)

_____, to be present for, and authorize treatment by the providers at Shoreline Orthopaedics, in the event

(Printed name of minor patient)

that I myself am unable to be present. I understand that I am still financially liable for any charges/treatment authorized by said person for my child.

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

Signature: _____ Date: _____

*****THIS FORM IS VALID FOR SIX (6) MONTHS FROM THE DATE SIGNED*****

Language assistance available Español | العربيـــة | 繁體中文 | Assyrian | Tiếng Việt | Shqip | 한국어 | বাংলা | Polski | Deutsch | Italiano | 日本語 | Русский | Srpsko-hrvatski | Tagalog	**Office Use Only** Expiration Date: _____ Staff Initials: _____