Shoreline Orthopaedics

Patient Registration Form

PATIENT: This section refers to the patient only **PARENT/GUARDIAN:** Complete PARENT/GUARDIAN section on the back of this form

Legal Name:	SSN:	Sex:	Date of Birth:
Address:	City/State/Zip:		
Employer:	Home Phone: ( )	Work Phone: ( )	
Email:		Cell Phone: ( )	

INSURANCE/BILLING: Please complete this section for the person/persons responsible for any insurance for this patient.

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? ☐ No ☐ Yes Date of Injury:_____

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

AUTHORIZATION TO BILL INSURANCE:

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 hereby give my permission to Shoreline Orthopaedic and Sports Medicine Clinic to release my medical records to the following physician(s):

Primary Care Physician: _____

Referring Physician: _____ **Initial Here:** ☐

Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Shoreline Orthopaedic & Sports Medicine Clinic 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 it 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.

Initial Here: ☐

FINANCIAL POLICY

I have reviewed and agree to the posted FINANCIAL POLICY (copies available upon request). **Initial Here:** ☐

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Are there any family members or other persons whom we may contact about your general medical condition and diagnosis (including treatment, payment and health care operations)? To authorize contact ONLY IN AN EMERGENCY check the "Emergency Only" box on the right.

Name: _____ Phone Number: ( ) _____ Emergency Only? ☐

Name: _____ Phone Number: ( ) _____ Emergency Only? ☐

(If more, continue on back of this form)

Can confidential messages (such as appointment reminders) be left on your telephone answering machine or voicemail?

Yes ☐ No ☐ **Initial Here:** ☐

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices of Shoreline Orthopaedic & Sports Medicine Clinic. I understand that Shoreline Orthopaedic & Sports Medicine Clinic reserves the right to change this Notice and will post a copy of the revised Notce in the waiting areas of the office and will provide me with a copy upon request.

Initial Here: ☐

By signing this form, I am consenting to Shoreline Orthopaedic & Sports Medicine Clinic's 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 Orthopaedic & Sports Medicine Clinic may decline to provide treatment to me.

Patient/Legal Representation Signature _____ **Date** _____

PARENT/GUARDIAN: Please complete this section if the pateint's parent or legal guardian is different than the person listed in the BILLING section

Name:	Relationship to Patient:	
Address:	SSN:	Date of Birth:
City/State/Zip:	Employer:	
Home Phone: ( )	Work Phone: ( )	

INSURANCE/BILLING: Please complete this section for the person/persons responsible for any insurance for this patient.

Third Insurance Company:		Other Insurance Company:	
Insured Name:	Date of Birth:	Insured Name:	Date of Birth:
Relationship to Patient:	SSN:	Relationship to Patient:	SSN:

ADDITIONAL AUTHORIZED CONTACTS:

Name: _____ Phone Number: ( ) _____ Emergency Only? ☐

Name: _____ Phone Number: ( ) _____ Emergency Only? ☐

Name: _____ Phone Number: ( ) _____ Emergency Only? ☐

Name: Phone Number: ( ) Emergency Only? ☐

FOR SHORELINE ORTHOPAEDIC USE ONLY

Acknowledgement of Receipt of Notice of Privacy Practices was presented to: _____

on: _____

Signature was not obtained for the following reason:

Signature of staff person: _____ Date: _____