

NEW PATIENT REGISTRATION FORM

DATE	APPOINTMENT WITH	MR #
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PATIENT INFORMATION

PATIENT'S LAST NAME/Apellido Del Paciente		FIRST NAME/Primer Nombre		DOB	AGE/Edad	SOCIAL SECURITY #
STREET ADDRESS/Direccion		APT. #	CITY/Ciudad	STATE	ZIP CODE	COUNTRY
				SEX/Sexo (CIRCLE ONE)		M F
HOME PHONE NO./Telephono ()	WORK PHONE NO. ()	MARITAL STATUS S M W D SP		SPOUSE'S NAME	SPOUSE'S WORK NO. EXT. ()	
PATIENT EMPLOYER/Patron Del Paciente'				F/T STUDENT Y N	ALLERGIES	
EMPLOYER'S ADDRESS/Direccion Del Patron		CITY/Ciudad	STATE/Estado		ZIP CODE	
EMERGENCY CONTACT PERSON/Contacto De Emergencia		RELATIONSHIP TO PATIENT		CONTACT'S HOME PHONE NO. ()	CONTACT'S WORK PHONE EXT. ()	
REFERRING MD NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO. ()	
PRIMARY DOCTOR NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO. ()	

GUARANTOR INFORMATION - Person responsible for payment, if other than self

GUARANTOR'S LAST NAME		FIRST NAME		RELATIONSHIP TO PATIENT	SOCIAL SECURITY #	DOB	HOME PHONE NO. ()
GUARANTOR'S ADDRESS		APT. #	CITY	STATE	ZIP CODE	COUNTRY	SEX/Sexo (CIRCLE ONE)
						align="center"> M F	
GUARANTOR'S EMPLOYER		ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE NO. ()	

INSURANCE INFORMATION

MEDICARE		EFF. DATE	MEDICAID #		EFF. DATE
PRIMARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #		CERTIFICATE #
ADDRESS		CITY	ZIP CODE	STATE	ZIP CODE
				PHONE NO. ()	
NAME OF INSURED		PATIENT RELATIONSHIP TO INSURED		SOCIAL SECURITY #	DOB
				SEX/Sexo (CIRCLE ONE)	
				align="center"> M F	
INSURED'S ADDRESS		APT. #	CITY	STATE	ZIP CODE
				COUNTRY	HOME PHONE NO. ()
INSURED'S EMPLOYER				WORK PHONE NO. ()	
SECONDARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #		CERTIFICATE #
ADDRESS		CITY	ZIP CODE	STATE	ZIP CODE
				PHONE NO. ()	
NAME OF INSURED		PATIENT RELATIONSHIP TO INSURED		SOCIAL SECURITY #	DOB
				SEX/Sexo (CIRCLE ONE)	
				align="center"> M F	
INSURED'S ADDRESS		APT. #	CITY	STATE	ZIP CODE
				COUNTRY	HOME PHONE NO. ()
INSURED'S EMPLOYER				WORK PHONE NO. ()	

AUTHORIZATION INFORMATION

ASSIGNMENT OF BENEFITS:

I hereby assign to Beth Israel Orthopedics and Sports Medicine any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR RELEASE OF INFORMATION:

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature of Patient/Legal Guardian: _____ Date: _____