

**ORTHOPAEDIC SPECIALISTS OF NORTH CAROLINA  
PATIENT REGISTRATION FORM**

Date \_\_\_\_\_

Chart # \_\_\_\_\_

**Dr. / Miss/ Mr./ Mrs./ Ms.** Patient Name \_\_\_\_\_  
(Please Circle One) First Name MI Last Name

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** Male/Female **Marital Status:** Married / Single / Divorced / Sep / Widow/er

**SS#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Who referred you to our office?** \_\_\_\_\_  
Name of Physician/Provider Practice Name

Address Phone Fax

**Patient Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **ST** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_ **Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_ **Work Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_

**Best number to contact you:** Home / Cell / Work **Okay to leave message on answering machine?** Yes / No

**Email Address** \_\_\_\_\_ **Race:** B W A H Other \_\_\_\_\_

**Patient's Employer Name and Address:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_  
Name Phone Relationship

**Responsible Party for Account/Billing:** Self / Spouse / Parent / Legal Guardian (Please circle one)

Name DOB Relationship

Phone Employer Name & Address Employer Phone

**Who is your Primary Care Physician?** \_\_\_\_\_  
Name of Physician/Provider Practice Name

Address Phone Fax

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

**Policy Holder:** Self / Spouse / Parent / Legal Guardian **Policy Holder:** Self / Spouse / Parent / Legal Guard.

**Policy Holder Name:** \_\_\_\_\_ **Policy Holder Name:** \_\_\_\_\_

**Policy Holder DOB :** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Policy Holder DOB :** \_\_\_\_/\_\_\_\_/\_\_\_\_

I consent to treatment necessary for the care of the above named person for whom I am legally responsible. I authorize the release of all medical records to the referring or primary care physician, or to other physicians as required for treatment and to my health insurance company, if applicable. I authorize transmission of medical information by fax. To promote better patient care, I give Orthopaedic Specialists of NC permission to retrieve my medication history. Any other release of medical information will necessitate a specific written authorization by me. I authorize any health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I acknowledge full financial responsibility for services rendered by Orthopaedic Specialists of NC. I understand that payment of charges incurred is due at the time of service unless other defined financial arrangements have been made prior to treatment. I further authorize and request that insurance payments be made directly to Orthopaedic Specialists of NC. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Seal)

I have received ORTHOPAEDIC SPECIALISTS OF NC'S Notice of Privacy Practices.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_