



CORE ORTHOPEDICS & SPORTS MEDICINE REGISTRATION INFORMATION

I. PATIENT INFORMATION:

Social Security No.: _____

Legal Name: _____ Age: _____ Date of Birth: _____

Sex: Male Female Status: Single Married Divorced Widowed Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Driver's License No.: _____ Employer's or School Name: _____

Employer or School Address: _____ City: _____ State: _____ Zip: _____

In case of Emergency, who should be notified? _____

Phone: _____ Relationship: _____

Who is your Medical Doctor or Primary Care Physician? _____

II. GURANTOR INFORMATION: (If different from Patient)

Social Security No.: _____

Legal Name: _____ Age: _____ Date of Birth: _____

Sex: Male Female Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Driver's License No.: _____ Employer's or School Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

III. PRIMARY INSURANCE INFORMATION

Name of Ins. Co.: _____ Policy ID No.: _____

Group No.: _____ Phone No.: _____ Co-Payment: \$ _____ Referral Needed: Yes No

If different than patient, fill in below:

Name of Policy Holder: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Employer: _____

IV. SECONDARY INSURANCE INFORMATION

Name of Ins. Co.: _____ Policy ID No.: _____

Group No.: _____ Phone No.: _____ Co-Payment: \$ _____ Referral Needed: Yes No

If different than patient, fill in below:

Name of Policy Holder: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Employer: _____

V. WORKER'S COMPENSATION OR LEGAL/ACCIDENT (If applicable)

Name Carrier: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone No.: _____ Claim No.: _____ Name of Adjuster: _____

Employer at Time of Accident: _____ Phone No.: _____

Name of Attorney: _____ Phone No.: _____

Verification of W/C: Yes No Date Made: _____ by: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage and assign directly to Core Orthopedics & Sports Medicine and its affiliates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the use of my health care information and such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services. The consent will end upon termination of coverage with the above-named Insurance Company(ies) or one year from the date signed below.

X _____

Signature of Patient, Parent, Guardian or Personal Representative

Date: _____

X _____

Signature of Patient, Parent, Guardian or Personal Representative

Date: _____

Parent Spouse Guardian/POA

Yearly Annual Review (Only Sign if Updating Form)

I have reviewed the above registration information and find it to be correct & updated.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Signature of Patient, Parent, Guardian or Personal Representative

Date