

**BONE & JOINT ASSOCIATES, LLP
PATIENT REGISTRATION**

LAST NAME: _____ FIRST: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

BEST TIME TO CALL _____ WHERE DO YOU PREFER TO RECEIVE CALLS? HOME WORK CELL

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ SEX Male Female

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION

MEDICARE PRIMARY SECONDARY Copy of Card Attached Yes No
ID#: _____

MEDICAID PRIMARY SECONDARY Copy of Card Attached Yes No
ID#: _____

COMMERCIAL/MANAGED CARE:
 PRIMARY SECONDARY Copy of Card Attached Yes No
ID#: _____

NO FAULT ****See attached worksheet****

WORKERS COMPENSATION ****See attached worksheet****

RESPONSIBLE PARTY

Self Spouse Parent Other

****Please fill out section below only if the guarantor is someone other than patient****

Name _____ Social Security # _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Employer _____ Occupation _____

I hereby authorize my insurance benefits be paid directly to the physician. I further authorize the release of any information to my insurance carrier concerning my illness and treatment. I understand that I am responsible for any deductibles, co-payments, and any non-covered services that may apply as directed by my insurance plan.

SIGNATURE: PATIENT/RESPONSIBLE PARTY _____

*******PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARDS AND DRIVER'S LICENCE TO COPY*******