Jennings Orthopaedic Associates, PA Patient Registration Form

Referring Doctor ____
Family Doctor ____

Patient Name ____
First Middle Maiden Last
Address ____
Phone (H) ______________(C) ______________(W) ______________
DOB:____________Age _____ SS# ______________E-Mail ______________

Martial Status __S___M___D___W ___Legally Separated ____Domestic Partner

Male _____ Female _____ Race/Ethnicity ______________________

Language Preference ______________________

Emergency Contact ______________________________

Relationship ______________Primary Phone ______________________

Responsible Party ______________________Relationship ______________

DOB ______________ SS# ______________________

Address ______________________________________

Patient's Employer ______________________________________

Primary Insurance
Carrier Name ______________________________________
Insured Name ______________________________ DOB ______________
SS# ______________________ID# ______________________Group # ____________
Employer ______________________________________
Secondary Insurance
Carrier Name ______________________________________
Insured Name ______________________________ DOB ______________
SS# ______________________ ID# ______________________ Group# ____________

Are either one of the above carriers a Cobra Plan __________ Yes ________ No

Financial Responsibility and Assignment of Insurance Benefits: I guarantee payment to Jennings Orthopaedic Associates, PA of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical benefits, which would otherwise be payable to me to Jennings Orthopaedic Associates, PA for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVII, and/or XIX of the Social Security Act is correct.
Consent for Healthcare and Release of medical Information: I voluntarily consent to healthcare treatment ("Treatment") from the physicians and staff at Jennings Orthopaedic Associates, PA and consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Signature of Patient or Authorized Person X______________________________Date ______________

Insured Party or Financial Guarantor (If different from above) X______________________Date ______________