

ROCKINGHAM ORTHOPAEDIC ASSOCIATES

REGISTRATION FORM

(Please Print)

| PATIENT INFORMATION | | |
|---|--|---------|
| Last Name: | First: | Middle: |
| Marital status: (check one) Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/> | SS #: | |
| Birth date: (mm/dd/yyyy) | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Age: |
| Street address: | Home Ph: () | |
| P.O. Box: | Mobile Ph: () | |
| City: | State: | ZIP: |
| Is this a Job Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, Date of Injury? (mm/dd/yyyy) | |
| Employer: | Ph: () | |
| Is this a Motor Vehicle Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, State Where Accident happened | |
| Is there an Attorney Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, Name of Attorney's Firm | |
| INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST) | | |
| Primary Insurance: | Secondary Insurance: | |
| ID# | ID# | |
| GROUP# | GROUP# | |
| If the Person Responsible for Payment is Different than Patient above OR Patient is Under Age 18 OR Patient is a Full-Time Student: | | |
| Responsible Person or Subscriber's Name: | | |
| SS #: | Birth date: (mm/dd/yyyy) | |
| Employer: | Ph: () | |
| Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and obtaining referrals from primary care physicians. I also authorize Rockingham Orthopaedic Associates, LLC or insurance company to release any information required to process my claims.

X

Signature of Person Responsible for Payment (Patient/Guardian)

Date