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OSSL

Orthopaedic Sports Specialists of Louisiana

PATIENT REGISTRATION FORM

ALL information must be completed. If not applicable please mark N/A.

Patient: _____
Last Name First Name MI

Today's Date: _____

If minor, Parent's name(s) _____

Patient's SS# _____

Address: _____

Date of Birth: _____

City: _____ State: _____ Zip: _____

Age: _____ Sex: M F

Other address: _____

Marital Status: S M D W Sep

Hm Ph: _____

Wk Ph: _____

Cell/Other: _____

Email: _____

Employer: _____

Occupation: _____

Primary care physician: _____

Ph: _____

Referring physician: _____

Ph: _____

INSURANCE INFORMATION

Primary Insurance: _____

Name of Insured: _____

Relationship to Insured: Self Husband Wife Child Other

Insured D.O.B. _____

Member ID #: _____ Group # _____

Insured SSN# _____

Secondary Insurance: _____

Name of Insured: _____

Relationship to Insured: Self Husband Wife Child Other

Insured D.O.B. _____

Member ID #: _____ Group # _____

Insured SSN# _____

Is this visit work or accident related? Yes No

Name of Responsible Party _____

Address _____

Ph: _____

List the name of the primary person to contact in case of an emergency:

Name: _____ Relationship: _____

Phone: _____

List the name(s) of family and/or friends that we may inform about your medical condition:

Name: _____ Relationship: _____

Phone: _____

Insurance Assignment and Release

I certify that I have insurance coverage with above listed company(ies) and assign directly to Orthopaedic Sports Specialists of Louisiana, 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 signature on all insurance submissions. The above named doctor/medical group may use my health care information and may disclose such information to the above-mentioned Insurance company(ies) and their agents for the purpose of coordinating care, obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, made either to me or on my behalf to Orthopaedic Sports Specialists of Louisiana for any services furnished to me by that provider group. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

I acknowledge that the information provided is complete and accurate to the best of my knowledge.

Patient/Designated Representative Signature

Printed Name

Date