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PATIENT REGISTRATION FORM

Please PRINT. 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

Marital Status: S M D W Sep

Other address: _____

Hm Ph: _____

Wk Ph: _____

Cell/Other: _____

Email: _____

Employer: _____

Occupation: _____

Primary care physician: _____

PCP Phone: _____

Referring physician: _____

Referrer Phone: _____

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# _____

THIRD PARTY LIABILITY INFORMATION

Is this visit work or accident related? Yes No Type of Accident _____

Name of Responsible Party _____

Address _____

Ph: _____

Name of attorney representing patient related to this service: _____

Attorney Phone: _____ Attorney's Address: _____

**EMERGENCY CONTACT **

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.

Billing and Collections

Orthopaedic Sports Specialists of Louisiana is providing services in good faith that it will be appropriately compensated in a timely manner. If necessary, the patient and/or guarantor will be held liable for any late fees, interests, collection fees, and/or reasonable attorneys' fees for the prosecution and/or collection of the patient amount owed. It is the patient's and/or guarantor's responsibility to provide Orthopaedic Sports Specialists with updated billing and insurance information on each and every visit.

I acknowledge that the information provided is complete and accurate.

Patient/Designated Representative Signature

Printed Name

Date