PATIENT REGISTRATION INFORMATION

PATIENT INFO

Name ____SSN:______________________

Address: _______________________________City/State/Zip________________________________

Employer:_________________________ Occupation: __________________ Full Time ___ Part-time___

Home Phone: ___________ Work Phone ___________ Mobile Phone: ___________ Other: ___________

Marital Status: Single:____ Married: ____ Divorced: ____ Widowed: ____ Sex:_______ Race: ________

Date of Birth: ____________________ Email address:____________________________________

► Did another physician refer you here today, if so which physician? ______________________________

► Who is your medical doctor? ____________________________________

Nearest Living Relative: (not living at the same address)

Name____ Home Phone__________________

Address _____________________________ City/State/Zip______________________________________

If patient is under 18, please fill out following information for responsible party:

Name: ___________________________ Date of Birth: ____________ Home Telephone _______________

Address: ____

City/State/Zip_________________________________ Employer:__________________________

SSN: _______________________ Relationship __________________ Occupation____________________

***Please Present Insurance Cards At Time of Registration**

INSURANCE INFORMATION 1.________________________ID#__________________

2.________________________ID#__________________

If Insured party is different from responsible party, Please fill out the following information:

Name: ___________________________ Date of Birth: ____________ Home Telephone _______________

Address: ____

City/State/Zip_________________________________ Employer:__________________________

SSN: _______________________ Relationship __________________ Occupation____________________

IS THIS CLAIM: Auto Accident: Yes _______No ________ Compensation: Yes _____ No _____
Injury: Yes ____ No _____Claim #___________________ Disability: Yes _______ No _______

LEGAL REPRESENTATION: Yes ____ No ____ Name and Address _____________________________________

How will you be paying today: Cash _________ Check ________ Credit Card________

Patient/Guarantor Please Read And Sign:

I request payment of health benefits to my attending physician whether it be Darrell C Belcher, M.D., Philip Branson, M. D., Rober Kropac, M.D. , or Frederick Morgan, D.O. for services rendered to me. I do however understand that I am responsible for all charges incurred. I authorize the Orthopaedic Center of the Virginias to release any information, verbal or written, to all parties involved regarding my medical condition. This is to include any medical records, reports, x-rays, or other related information. In th event that one of the above mentioned doctors should be overpaid, I hereby authorize Darrell C Belcher, M.D., Philip Branson, M. D., Robert Kropac, M.D. , or Frederick Morgan, D.O. overpayment to be applied to outstanding accounts with other physicians within this office.

→**Patient/Guarantor Signature** X____________________________________Date___________