

MEEKS & ZILBERFARB ORTHOPEDIC ASSOCIATES, PC

PATIENT REGISTRATION FORM

New Patient Update of Information

Patient Name: _____ Date of Birth: _____ Sex: Male Female

Address: _____ Town: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Soc. Sec. #: _____

Primary Care Physician: _____ Telephone: _____

Address: _____

Referring Physician: _____ Telephone: _____

Employer Name & Address: _____

Primary Insurance Company: _____

Address: _____

Telephone: _____ Certificate #: _____ Group #: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Soc. Sec. #: _____ Relationship to Patient: Self Spouse Dependant Child

Secondary Insurance Company: _____

Address: _____

Telephone: _____ Certificate #: _____ Group #: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Soc. Sec. #: _____ Relationship to Patient: Self Spouse Dependant Child

Is this visit related to an accident? Yes No Work Related: Yes No Auto Related? Yes No Injury Date: _____

Other: _____ Is there an attorney related with this accident? Yes No

Employer/Auto/Liability Insurance Company: _____

Address: _____

Telephone: _____ Claim #: _____ Claim Representative: _____

ASSIGNMENT: I hereby authorize Medicare/Insurance benefits to be made to the above named provider(s) for surgical and/or medical services furnished to me. _____ Signature: _____

RELEASE: I hereby authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable to related services. _____ Signature: _____

MEDICAL RECORD(S): I hereby authorize any holder of medical information about me to release to another physician for the purpose of referral and continued medical care. _____ Signature: _____

Date: _____

MEDICATION RENEWAL POLICY: MONDAY THROUGH FRIDAY DURING BUSINESS HOURS WHEN CHART IS AVAILABLE