ASHEVILLE ORTHOPAEDIC ASSOCIATES

*setting the pace of orthopaedic care*

# REGISTRATION FORM

TODAY'S DATE: ACCOUNT #:

**FIRST NAME:** **MI:** **LAST NAME:** **SSN:**

**DOB:** **AGE:** **MARITAL STATUS:** **SEX:**

**ADDRESS:** **ZIP:** **CITY:** **STATE:**

**PRIMARY PHONE** (number you wish to be reached at): **OTHER #:** ______________________

**E-MAIL:** ______________________________________

**OCCUPATION**: ____________________ **WORK No:** **EMPLOYER:**

**EMPLOYMENT STATUS:** ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled

**STUDENT STATUS:** ☐ Full Time ☐ Part Time ☐ Not a Student

**RACE**: _________________ **ETHNICITY:** _____________ **PREFERRED LANGUAGE:** ____________

In Case of **EMERGENCY**, Notify:
Name: ______________________________ Relationship: ______________ Phone No: _________________

If Patient is a Minor, please provide name of Parent or Legal Guardian:
Name: ________________________________________ Relationship to Patient: _______________________

Is This an Injury? ☐ Yes ☐ No Liability Insurance: ______________________________________
Is this Work Related? ☐ Yes ☐ NO Date of Injury: _______________________

**PRIMARY CARE PHYSICIAN**: _______________________________ Phone: ______________________
Address: ______________________________________ City: _____________________ State: ___________

Who Referred You To Our Office?
**REFFERING PHYSICIAN'S** NAME: ______________________________ Phone: ____________________
Address: ______________________________________ City: _____________________ State: ___________

☐ FAMILY

☐ FRIEND

☐ INSURANCE COMPANY ☐ PHONE BOOK ☐ PATIENT PORTAL ☐ WEB SITE

## Insurance Information

**PRIMARY** INSURANCE: _____________________ **INSURED'S NAME:** ________________________
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

**POLICY #:** _______________________________ **GROUP #:** _________________________________
Policy Holder's DOB: __________ SSN: _______________________ Employer: ______________________

**SECONDARY** INSURANCE:____________________ **INSURED'S NAME:** _______________________
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

**POLICY #:** _______________________________ **GROUP #:** __________________________
Policy Holder's DOB: __________ SSN: _______________________ Employer: ______________________

Appt Date: Appt Time: Provider:
Appt Reason: -

# ASHEVILLE ORTHOPAEDIC ASSOCIATES, P.A.

**Patient Name:** ______________________________ **DOB:** ___________ **Account #:** ____________

## AUTHORIZATION

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Asheville Orthopaedic Associates. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Asheville Orthopaedic Associates, P.A. to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_______________________________________________________ Date ________________

Are you the Guarantor? Yes__ No __ If not please see receptionist.

## CONSENT FOR TREATMENT

HIPAA

Having voluntarily presented myself (or my dependent) to Asheville Orthopaedic Associates, P.A., I acknowledge recognition of the fact that the evaluation and treatment received from Asheville Orthopaedic Associates, P.A. is advised and deemed necessary to be the judgment of the Physician.

X Signature_______________________________________________________ Date ________________

## CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

As a patient I agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Asheville Orthopaedic Associates, P.A. to disclose my personal medical information to the following individual(s).

____Asheville Orthopaedic Associates, P.A. may disclose my medical information only in my presence.

____Asheville Orthopaedic Associates, P.A. may disclose my medical information when I am not present; this includes telephone calls, fax or mail.

____I understand that this consent may be revoked by me at anytime by written notice of Asheville Orthopaedic Associates.

Name ________________________________________ Relation ___________ Phone _________________

Name ________________________________________ Relation ___________ Phone _________________

Name ________________________________________ Relation ___________ Phone _________________

_______ **Person(s) listed above age 18 or older may pick up prescription when I am not present.**

X Signature_______________________________________________________ Date ______________