



PATIENT REGISTRATION

Personal

Name _____

Address _____
Street City State Zip

Home Phone _____ Cell _____ Work _____

Date of Birth _____ SSN# _____

Marital Status Single Married Widowed

Email Address _____

Employer _____ Occupation _____

Employer Address _____
Street City State Zip

Phone _____

Notify in Event of Emergency _____
Phone # Name Relationship

Insurance Carrier

(Primary) Insurance _____ ID # _____ Group # _____

Insured's Name _____ Relationship to Patient _____
(if other than patient)

Insured's Social Security # _____ Date of Birth _____

Employer's Name _____ Employer's Phone # _____

Employer's Address _____

(Secondary) Insurance _____ ID# _____ Group# _____

Insured's Name _____ Relationship to Patient _____
(if other than patient)

Insured's Social Security # _____ Date of Birth _____

Employer's Name _____ Employer's Phone # _____

Employer's Address _____

How did you hear about Southern Orthopaedic Specialists?

Physician Friend Relative Name _____
 Advertisement Phone Book Other

Primary care physician:

Name _____ Phone _____

Address _____
Street City State Zip

**** Southern Orthopaedic Specialists will be happy to file the initial claim to your medical insurance carrier. As a courtesy, our office will follow-up with an appeal to the carrier. If these efforts do not generate payment in a timely manner, Southern Orthopaedic Specialists will provide patient with the necessary paperwork to file their medical claim ****

Authorization to Pay Benefits to Physician: I hereby authorize payment of medical benefits directly to Southern Orthopaedic Specialists. I understand that co-payments, deductibles, out of pocket expenses, non-covered services and balance due after insurance payments are due at the time of service, unless prior arrangements have been made with the office administrator. Southern Orthopaedic Specialists will bill my insurance for services rendered. I understand that payment is due within 30 days of receipt of this claim form. If my insurance does not pay within 30 days, I understand I am responsible for payment of the bill and/or contacting insurance company to secure payment. Southern Orthopaedic Specialists will notify me if my plan requires further information or other medical records. A photocopy of this authorization may be honored as valid. This authorization is valid until revoked by me in writing.

Authorization to Release Information: I hereby authorize Southern Orthopaedic Specialists to release any medical information necessary to process any insurance claim. This may be in the form of copies of medical records or information conveyed via telephone or telefax to my insurance company and/or any referral provider and/or any other necessary third party and/or its agents (collectively referred to as "the Plan.") I also authorize this facility to disclose any medical information necessary to the Plan to verify services, conduct quality, chart, site, or utilization reviews, investigate grievances. The Plan may need information to pre-certify services, medication, medical equipment, or physical therapy. The Plan may review my financial records. The Plan may review my medical chart in your office for proper documentation or for their studies as a measure of quality. My referring physician will receive a copy of your chart notes regarding my visit. This authorization also releases to the Health Care Financing Administration (HCFA) or its medical claims agencies any information referred to as "the Plan." I hereby authorize Southern Orthopaedic Specialists to release any medical information needed to administer Title XVIII (the Medicare program) of the Social Security Act. A photocopy of this authorization may be honored as valid. This authorization is valid until revoked by me in writing.

Patient's Signature (self, for minor, parent or guardian)

PRINT Patient's Full Name

Today's Date

Print, complete and fax/email to:

Fax: (504) 899-7317 • Email: Main@southern-ortho.com

