

Southern Orthopaedic Specialists

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Patient Registration Form

Patient Information

Name _____ Male Female
Last First Middle Choose not to disclose

Address _____
City State Zip

Home Ph (____) _____ Cell Ph (____) _____ Work Ph (____) _____

Date of Birth ____/____/____ SS#: _____ - _____ - _____ Single Married Widowed Divorced
(Circle One)

Personal Email _____ **Primary Care Physician:** _____

Language: English Spanish Vietnamese French Other: _____

Race: Hispanic Asian Caucasian African American Other: _____

Ethnicity: Hispanic Non-Hispanic Other

Insured Party

(Please OMIT SECTION if self)

Name _____ /____/____
First M.I. Last Date of Birth

Address _____
City, State, Zip

Relationship _____ Social Security # _____ - _____ - _____

Emergency Contact

Name Phone Relationship

INSURANCE INFORMATION

Primary Insurance

Insurance Carrier

Name/DOB of Insured (if different from patient)

Secondary Insurance

Insurance Carrier

Name/DOB of Insured (if different from patient)

Authorization to Pay Benefits to Physician: I hereby authorize Southern Orthopaedic Specialists to furnish information to insurance carriers concerning my illnesses and treatment, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. **I understand that I am responsible for any amount not covered by insurance.** I understand that if 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. A photocopy of this authorization and assignment 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. 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.

I understand that payment for services rendered is due at the time of the visit. **If I fail to do this, I may be assessed a \$15 late fee.**

X _____ **Date:** _____
Patient/Guardian Signature

HIPAA – Notice of Privacy Practice

The HIPAA notice is a 5-page explanation of the privacy act. This is a form explaining that Southern Orthopaedic Specialists will not release your information to anyone without your consent. **If you would like a copy of the privacy notice, please ask the receptionist.**

I _____ give Southern Orthopaedic Specialists, a division of LMG, LLC, permission to discuss my care with (please select one):

NO ONE

The following individual(s):

X _____ **Date:** _____
Patient/Guardian Signature

