PATIENT REGISTRATION FORM – PLEASE PRINT

Date of Visit

SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C.

Primary Care Physician and Phone Number:

PATIENT INFORMATION

Last Name	Suffix (Jr, etc.)	First Name	M.I.	Age

Street Address	Zip Code	City	State

Soc. Sec. No.	Home Phone	Work Phone	Cell Phone	Sex		Marital Status				D.O.B.
				M	F	S	M	W	D	

Patient's Employer	Work Address	Employer's Phone

RESPONSIBLE PARTY INFORMATION

Relationship to Patient	Name	Social Security No.	Driver's License No.

Street Address	Zip Code	City	State

Home Phone	Work Phone	Cell Phone	Name of Employer

Employer's Street Address	Zip Code	City	State

INSURANCE INFORMATION

PRIMARY INSURANCE			SECONDARY INSURANCE		
Name of Insurance Company			Name of Insurance Company		
Policy No.	Group No.	Effective Date	Policy No.	Group No.	Effective Date
Relationship to Patient	Name of Insured		Relationship to Patient	Name of Insured	
Date of Birth	Insured's Employer	Copay $	Date of Birth	Insured's Employer	Copay $

INJURY INFORMATION

Job Related? ☐ Yes ☐ No	Date of Injury	Date Last Worked	Employer at Time of Injury

Workmans' Compensation Carrier	Where were you injured?

How did your injury occur?	Employer rep. who authorized treatment

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

Person to contact	Relationship	Phone Number

Street Address	City	State	Zip

AUTHORIZATION AND RELEASE

I hereby authorize SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C. (SOS) to release for insurance purposes any information acquired in the course of my examination or treatment. I authorize payment from my insurance company to be made directly to SOS for any treatment I receive while under their care. I will be responsible for any charges not paid by my insurance company.

I understand that I am responsible for payment of my account, and I agree to pay all costs of collection and interest charges, including a reasonable attorney's fee.

_____ _____

Patient's/Responsible Party's Signature Date