PATIENT REGISTRATION

PATIENT INFORMATION

NAME (Last, First, Middle)		SS #	DATE OF BIRTH	SEX ☐ M ☐ F
LOCAL ADDRESS	APT/UNIT	CITY, STATE, ZIP		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED	RACE	ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC NOR LATINO ☐ REFUSED TO REPORT		
EMPLOYMENT STATUS	STUDENT STATUS	WHO REFERRED YOU? ☐ FAMILY OR FRIEND ☐ WEB/INTERNET SITE ☐ OTHER:		
EMPLOYER		PHONE #		
EMPLOYER ADDRESS		CITY, STATE, ZIP		
PRIMARY CARE PHYSICIAN	PHONE #	REFERRING PHYSICIAN	PHONE #	

GUARANTOR / RESPONSIBLE PARTY

☐ PATIENT ☐ OTHER: RELATIONSHIP:	GUARANTOR / RESPONSIBLE PARTY EMPLOYER
GUARANTOR / RESPONSIBLE PARTY NAME	GUARANTOR / RESPONSIBLE PARTY PHONE ☐ HOME ☐ CELL
GUARANTOR / RESPONSIBLE PARTY ADDRESS	GUARANTOR / RESPONSIBLE PARTY SS #
GUARANTOR / RESPONSIBLE PARTY CITY, STATE, ZIP	GUARANTOR / RESPONSIBLE PARTY DATE OF BIRTH

PRIMARY INSURANCE INFORMATION

NAME OF INSURED PARTY (MAIN SUBSCRIBER)		RELATIONSHIP TO PATIENT
ADDRESS OF INSURED PARTY	APT/UNIT	CITY, STATE, ZIP
DATE OF BIRTH OF INSURED PARTY	SS # OF INSURED PARTY	PHONE # OF INSURED PARTY
NAME OF INSURANCE		POLICY #
ADDRESS OF INSURANCE COMPANY		GROUP # / GROUP NAME
CITY, STATE, ZIP		PHONE #

SECONDARY INSURANCE INFORMATION

NAME OF INSURED PARTY (MAIN SUBSCRIBER)		RELATIONSHIP TO PATIENT
ADDRESS OF INSURED PARTY	APT/UNIT	CITY, STATE, ZIP
DATE OF BIRTH OF INSURED PARTY	SS # OF INSURED PARTY	PHONE # OF INSURED PARTY
NAME OF INSURANCE		POLICY#
ADDRESS OF INSURANCE COMPANY		GROUP # / GROUP NAME
CITY, STATE, ZIP		PHONE #

(TURN OVER PLEASE)

PATIENT NAME _____ **DATE OF BIRTH** _____

INJURY DATA INFORMATION	
DATE OF INJURY OR ONSET OF SYMPTOMS	WHERE DID YOUR INJURY OCCUR? ☐ WORK ☐ AUTO ☐ HOME ☐ SCHOOL ☐ OTHER:
CLAIM / CASE MANAGER	CLAIM / CASE #

EMERGENCY CONTACT	
NAME	PHONE #
RELATIONSHIP TO PATIENT	ALTERNATE PHONE #

PRESCRIPTION HISTORY CONSENT

I, _____ authorize Restore Orthopedics and Spine Center to retrieve my prescription history through an external source.

_____ _____

SIGNATURE OF PATIENT/ GUARANTOR / GUARDIAN DATE

I hereby authorize and consent to examination and treatment as deemed necessary by physicians of Restore Orthopedics and Spine Center. I authorize release of information to my insurance carrier should it be necessary. I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Restore Orthopedics and Spine Center. Photo ID and insurance cards must be presented at time of service. Should Photo ID and insurance cards not be presented I will become a cash patient with payment in full at time of service. I further authorize the release of all information necessary to secure payment. I agree to pay any costs incurred by Restore Orthopedics and Spine Center in the collection of amounts due including, but not limited to, reasonable attorney's fees. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

_____ _____

SIGNATURE OF PATIENT/ GUARANTOR / GUARDIAN DATE