PEE DEE ORTHOPAEDIC ASSOCIATES, PA

Patient Registration Data Form

PDOA Doctor_______________

Patient Information ***Pt Account No___________________________***

Patient Full Name____Date________________

Address____

City______________________________________ State__________Zip____________________

Home Phone (_____)_______________________ Cell Phone No (_____)________________________

Date of Birth________________ Social Security No_________________________Race___________

Male___Female___Employed? Full____Part_____ Married_____Single____Divorced_____Widow____

Student? Full time______Part time______ Employer____

Occupation_______________________________Pharmacy__________________________________

Location of pharmacy / street & city____

Employer Phone(_____)_____________________ Family Doctor____________________________

Referred by Dr.____________________________ Spouse's Name_____________________________

Spouse's Employer__________________________ Emergency Contact_________________________

Relationship_______________________________ Telephone No.(   )________________________

Insurance Information

Primary Insurance	***Secondary Insurance***
Ins Co Name_______________________________	Ins Co Name_____________________________
Policy No._________________________________	Policy No.______________________________
Account/Group Number______________________	Account/Group Number____________________
Policy Holder's Name_______________________	Policy Holder's Name_____________________
Policy Holder's Date of Birth________________	Policy Holder's Date of Birth______________
Policy Holder's Social Security #______________	Policy Holder's Social Security #____________
Patient's relationship to Policy Holder:	Patient's relationship to Policy Holder:
Self____Spouse____Child____Other____	Self____Spouse____Child____Other____

Current Medical Problem

What part of the body are we treating today?____

When did this problem begin?______/______/_______ If accident, give date of accident ____/____/_____

Were you injured on the job? Yes____No_____Were you injured in an auto accident?Yes_____No_____

State auto accident happened_____________If accident, what happened__________________________

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Were X-Rays taken? Yes____No____ If yes, where were they taken?____________________________

Do you have an Attorney? Yes____No____ If yes, Name of Attorney___________________________

Continued on Reverse Side

Pee Dee Orthopaedic – Patient Registration Form – Continued

Authorization for Treatment

I hereby authorize treatment,
Patient Signature (Guardian if minor)____Date_____________

Benefit Assignment/Agreement to Pay

I hereby authorize my insurance benefits to be paid directly to Pee Dee Orthopaedic Associates, PA. I understand that I am responsible to Pee Dee Orthopaedic Associates, PA for payments made directly to me and for any services or charges not covered by my insurance carrier.

Signature of
Claimant or Guardian____ Date _____________

Authorization to Release Medical Information

I hereby authorize Pee Dee Orthopaedic Associates, PA to release medical information (which may include treatment for physical/emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS or AIDS-related information) to my, or the patient's insurance carrier and its designates.

Signature of
Claimant or Guardian____ Date_________________

Receipt of Notice of Privacy Practices

I, the undersigned, have received a copy of Pee Dee Orthopaedic Associates, P.A.'s Notice of Privacy Practices.

Signature of
Claimant or Guardian____Date__________________

Names of Family or Friends To Whom We May Release Medical Information:

Name____ Relationship_________________________

Name____ Relationship_________________________

Revised 2/19/2008