☐2790 Clay Edwards Drive, Suite #650
North Kansas City, MO 64116

☐9151 NE 81st Terrace, Suite #200
Kansas City, MO 64158

☐203 NW R.D. Mize Road, Suite #250
Blue Springs, MO 64014

☐Cameron
☐Carrollton
☐Ray County/Richmond
☐Excelsior Springs

ORTHOPEDIC SURGEONS, INC

PATIENT REGISTRATION FORM

Today's Date: _____

Primary Care Physician: _____ PCP Phone: _____

Patient's Name:_____ M.I.:_____ Last: _____

Patient's Address:_____ City:_____ State:_____ Zip: _____

Patient's Phone:_____ Secondary:_____ Date of Birth: _____

Current Age:_____ Sex: ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W Spouse's Name: _____

(If minor) Parent's Name:_____ Parent's SS #: _____

Emergency Contact (not living with you):_____ Phone #: _____

Are you being seen today for an accident or injury ? ☐Yes ☐No ***If Yes, Accident Info must be completed on back**

If so, do you have an attorney representing you ? ☐Yes ☐No

Attorney Name:_____ Attorney Phone #:_____

Patient (or) Parent Occupation: _____ How Long ?_____

Patient (or) Parent Employer: _____ Telephone: _____

Employer's Address:_____ City:_____ State:_____ Zip: _____

Primary Insurance Co:_____ Effective Date: _____

Address:_____ City/State/Zip:_____

Phone:_____ Policy #:_____ Group #:_____ Co-Pay Amt. $ _____

Policy Holder:_____ Policy Holder's DOB:_____ Policy Holders SS#:_____

Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Son ☐Daughter ☐Policy Holders Employer: _____

Secondary Insurance Co:_____ Effective Date:_____

Address:_____ City/State/Zip:_____

Phone:_____ Policy #:_____ Group #:_____ Co-Pay Amt. $ _____

Policy Holder:_____ Policy Holder's DOB:_____ Policy Holders SS#:_____

Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Son ☐Daughter ☐Policy Holders Employer: _____

Patient's Name:_____ **Date of Birth:** _____

Work Injury Information:

Are we seeing you on this date for a work injury? ☐Yes ☐No

If so, has your company been informed? ☐Yes ☐No **Date Informed:** _____

Name of Work Contact: _____

Date Injured:_____ **Body Part Injured:** _____

In your own words, please describe what happened. _____

_____

_____

Other Accident Injury Information:

Where did Accident/Injury occur ?_____

In your own words, please describe what happened. _____

_____

Who Is Responsible - other than Health Insurance - for your charges ? _____

Automobile Injury/Accident Information:

Are we seeing you on this date for a vehicle accident / injury? ☐Yes ☐No

If so, has your automobile insurance company been informed? ☐Yes ☐No

Name of Person Informed:_____ **Date Informed:**_____

Date of Accident/Injury:_____ **Body Part Injured:** _____

Name of Auto Insurance: _____ **Insurance Agent/Adjuster:** _____

Auto Insurance Address:_____ **City:**_____ **State:**___ **Zip:**_____

Policy #: _____ **Policy Holder:** _____

Policy Effective Date: _____ **Insurance Claim #:** _____

I hereby authorize payment directly to Orthopedic Surgeons, Inc., of all insurance coverage for surgery and/or office charges, and I authorize them to release any information necessary to process insurance benefits on my behalf. I also authorize the release of my medical records to any insurance company with whom I have health insurance coverage.

I understand that doctor and office fees are due and payable when services are rendered. I understand that I am fully responsible for all charges and any balance due after payment by insurance, and that insurance coverage does not necessarily guarantee payment of charges. I also understand that any account balance over 120 days will be assessed a finance charge, and/or a billing charge. Further, should legal collection become necessary I will be responsible for any fees associated with collecting any outstanding debt.

A copy of your insurance card(s) and drivers license is required.

I, the undersigned, agree to the terms set forth in this paragraph, and authorize treatment by the doctor(s) in this office.

Signature:_____ Date:_____

I have received a copy of the "Notice of the Privacy Practices" from Orthopedic Surgeons, Inc. _____
initials