

ORTHOPAEDICS NORTHEAST, P.C.

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PATIENT REGISTRATION FORM

PERSONAL INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____
SOCIAL SECURITY # _____ MARITAL STATUS _____ MALE _____ FEMALE _____
HOME ADDRESS _____ CITY, STATE, ZIP _____
HOME TELEPHONE # _____ CELL PHONE # _____
EMPLOYER NAME _____ WORK PHONE # _____
EMPLOYER ADDRESS _____ CITY, STATE, ZIP _____
IN CASE OF EMERGENCY PLEASE NOTIFY NEXT OF KIN
NAME _____ PHONE # _____

IF UNDER 18, PERSON/PERSONS LEGALLY RESPONSIBLE FOR PATIENT
NAME _____ PHONE # _____
ADDRESS _____ CITY, STATE, ZIP _____

INJURY INFORMATION

IS THIS INJURY DUE TO: AUTO ACCIDENT _____ WORK INJURY _____
DATE OF INJURY _____ OTHER ACCIDENT/INJURY _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____ PRIMARY DOCTOR _____
ID OR MEMBER # _____ GROUP OR POLICY # _____
SUBSCRIBER NAME _____ RELATION TO PATIENT _____
SUBSCRIBER'S BIRTHDATE _____ SUBSCRIBER'S SOCIAL SECURITY # _____
SUBSCRIBER'S EMPLOYER NAME _____ ADDRESS _____

SECONDARY INSURANCE NAME _____ PRIMARY DOCTOR _____
ID OR MEMBER # _____ GROUP OR POLICY # _____
SUBSCRIBER NAME _____ RELATION TO PATIENT _____
SUBSCRIBER'S BIRTHDATE _____ SUBSCRIBER'S SOCIAL SECURITY # _____
SUBSCRIBER'S EMPLOYER NAME _____ ADDRESS _____

ASSIGNMENT OF BENEFITS

I hereby authorize assignment of payments directly to ORTHOPAEDICS NORTHEAST, P.C. for any surgical and/or medical benefits, which are payable to me for this service described above. I understand that I am financially responsible for the charges not covered by this assignment of benefits or my insurance. I hereby authorize ORTHOPAEDICS NORTHEAST, P.C. to release any information relative to medical care received by me for purposes of treatment and/or payment. Furthermore, by signing below, I declare that I have received a copy of ORTHOPAEDICS NORTHEAST, P.C.'s Privacy Precautions.

SIGNATURE (MUST BE 18 TO SIGN)

DATE