PATIENT REGISTRATION FORM (please print clearly)

The Centers for Advanced Orthopaedics
Anne Arundel Orthopaedic Surgeons

TODAY'S DATE				
PATIENT'S NAME – FIRST MIDDLE LAST			MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	SEX ☐ MALE ☐ FEMALE
HOME ADDRESS – STREET	APT. #	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS	
DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	OCCUPATION	
EMPLOYER	ADDRESS – STREET	CITY	STATE	ZIP
SPOUSE OR PARENT NAME	SPOUSE OR PARENT EMPLOYER	ADDRESS	WORK PHONE	
IN CASE OF EMERGENCY NOTIFY	ADDRESS	HOME PHONE	WORK PHONE	
FINANCIALLY RESPONSIBLE PERSON ☐ SELF ☐ SPOUSE ☐ PARENT ☑ OTHER	NAME (IF DIFFERENT THAN PATIENT)			
ADDRESS (IF DIFFERENT FROM PATIENT)	HOME PHONE	WORK PHONE		
NAME OF PREFERRED PHARMACY	LOCATION	PHONE NUMBER		

HOW WERE YOU REFERRED? ☐ PRIMARY CARE DOCTOR ☐ ER ANNE ARUNDEL HOSPITAL ☐ OTHER ER ☐ SELF ☐ FRIEND

☐ RELATIVE ☐ WEB SEARCH ☐ YELLOW PAGES ☐ COACH ☐ OTHER (PLEASE PROVIDE WHOM) _____

HEALTH INSURANCE INFORMATION

IS INJURY ☐ JOB RELATED ☐ RESULT OF AUTO ACCIDENT ☐ PERSONAL ACCIDENT INVOLVING LIABILITY

HEALTH INSURANCE CO. NAME	INSURANCE CO. ADDRESS		
ID/POLICY NO.	GROUP NO.	EFFECTIVE DATE	
POLICYHOLDER	POLICYHOLDER'S RELATION TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	SOCIAL SECURITY NO.	DATE OF BIRTH
INSURED'S EMPLOYER	ADDRESS	WORK PHONE	
SECONDARY INSURANCE COVERAGE	INSURANCE CO. ADDRESS		
ID/POLICY NO.	GROUP NO.	EFFECTIVE DATE	
POLICYHOLDER	POLICYHOLDER'S RELATION TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	SOCIAL SECURITY NO.	DATE OF BIRTH
INSURED'S EMPLOYER	ADDRESS	WORK PHONE	

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I hereby authorize the release of any medical information necessary to process an insurance claim and do assign to the doctor all money to which I am entitled for medical and/or surgical expenses relative to this case. I understand that I am financially responsible to the doctor for all charges not covered by this assignment. I understand that payment for services are due at the time of service.

SIGNATURE_____ DATE_____

INTEROFFICE USE ONLY

ACCT#_____ DOCTOR_____ RECEPTIONIST_____ DATE_____

IS INJURY □ **JOB RELATED** □ **RESULT OF AUTO ACCIDENT** □ **PERSONAL ACCIDENT INVOLVING LIABILITY**

IF INJURY IS RELATED TO ANY OF THE ABOVE, PLEASE COMPLETE APPROPRIATE SECTION, OTHERWISE READ AND SIGN LAST SECTION.

FOR WORK RELATED INJURIES

EMPLOYER AT TIME OF ACCIDENT	**DATE OF INJURY**
ADDRESS	**PHONE**

WAS INJURY REPORTED TO SUPERVISOR? □**YES** □**NO**	**NAME OF SUPERVISOR**
DESCRIPTION OF INJURY	
ATTORNEY'S NAME	**PHONE**
ADDRESS	
WORKER'S COMPENSATION CARRIER	
ADDRESS	**ADJUSTOR'S NAME**
CLAIM NUMBER	**PHONE**

FOR AUTO OR PERSONAL ACCIDENT (LIABILITY)

DATE OF ACCIDENT	**LOCATION/DESCRIPTION OF ACCIDENT**
YOUR AUTO INSURANCE CO.	
PIP CARRIER	**INSURED**
ADDRESS	**ADJUSTOR'S NAME**
CLAIM #	**PHONE**
ATTORNEY'S NAME	**PHONE**
ADDRESS	
OTHER INSURANCE CO.	**INSURED**
ADDRESS	**ADJUSTOR'S NAME**
CLAIM #	**PHONE**

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment at the time of service.

SIGNATURE_____ **DATE**_____

Patient Signature or Guardian, if minor