

# WELCOME TO RIVERSIDE ORTHOPAEDIC & SPORTS MEDICINE ASSOCIATES

<p><b><u>How were you referred to this office?</u></b></p> <p> <input type="checkbox"/> Friend/Relative                      <input type="checkbox"/> Other  <input type="checkbox"/> Insurance Directory                <input type="checkbox"/> St. Luke's ER  <input type="checkbox"/> Physician                                 <input type="checkbox"/> Roosevelt ER         </p>	<p><b><u>Referring Physician:</u></b></p> <p>_____</p> <p><b><u>Primary Care Physician (if different from above):</u></b></p> <p>_____</p>
--	--

**IS THIS WORK RELATED?** YES  NO       **IS THIS DUE TO AN AUTO-ACCIDENT?** YES  NO

**DATE:** \_\_\_/\_\_\_/\_\_\_

**Your E-MAIL ADDRESS:** \_\_\_\_\_

(PLEASE PRINT)

<b>PATIENT INFORMATION</b>	NAME: First                      Middle                      Last			SOC SEC #		DOB		
	ADDRESS:			CITY:		STATE:                      ZIP:		
	HOME #:		WORK #:		CELL #:		SEX: (Circle)	MARITAL STATUS (Circle)
							FEMALE / MALE	S      M      W      D
	PATIENTS EMPLOYER:				SPOUSE NAME:		EMPLOYER:	
	ADDRESS:				EMPLOYERS ADDRESS:			
	CITY:				CITY:			
STATE:                      ZIP:				STATE:                      ZIP:				
<b>INSURANCE</b>	PRIMARY INS CO.			POLICY HOLDERS NAME:			POLICY HOLDERS DOB:	
	ADDRESS:			ID #				
	CITY:                      STATE:                      ZIP:			GROUP #:				
	SECONDARY INS CO.			POLICY HOLDERS NAME:			POLICY HOLDERS DOB:	
	ADDRESS:			ID # :				
	CITY:                      STATE:                      ZIP:			GROUP #:				
<b>EMERGENCY CONTACT</b>	NAME: First                      Middle                      Last			RELATIONSHIP TO PATIENT:				
	HOME #:		WORK #:		CELL #:			
	ADDITIONAL INFORMATION:							

*All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payment. However, the patient is responsible for all fees, co-payments and deductibles, regardless of the insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.*

I request that payment of authorized insurance benefits be made either to me or on my behalf to Riverside Orthopaedic and Sports Medicine for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers of Medicare, Medicaid, and any other third party insurance carrier any information needed to determine these benefits payable for related services.
--

I have read this registration form and state that all the information given by me to be valid and true.

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Effective 1/1/05