

BALLARD ORTHOPEDIC & FRACTURE CLINIC

A Division of Proliance Surgeons Inc., P.S.

PATIENT REGISTRATION

Patient Name _____ Male () Female ()
Last First Middle Initial (Nickname)

Home Address _____ Home Phone () _____
Street Apt. # Area Code

City State Zip

Marital Status: Single () Married () Separated () Divorced () Widowed () Dependent ()

Birthdate ____ / ____ / ____ Age ____ Social Security # _____

Primary Care Physician _____ Home Phone () _____
Area Code

Are you consulting an attorney for this injury? Yes / No If yes, Name & Phone # _____

Referred by Dr. / Patient / Friend _____

Patient's Employer / School _____ Work Phone () _____
Area Code

Employment / School _____ Occupation _____
Street Address

City State Zip

Parent / Spouse Name _____ Employer _____ Phone _____

BILLING INFORMATION

Name of person responsible for bill _____ Relationship Social Security #

Address (if not as above) _____ City State Zip

Home Phone _____ Employer _____

Work Phone _____ Address _____

IN ORDER TO BILL YOUR INSURANCE, WE MUST HAVE A COPY OF YOUR CARD

PRIMARY INSURANCE

SECONDARY INSURANCE

Ins. Co. Name _____

Ins. Co. Name _____

Subscriber Name _____

Subscriber Name _____

Date of Birth _____

Date of Birth _____

Group # _____ ID# _____

Group # _____ ID# _____

Subscriber's Employer _____

Subscriber's Employer _____

Does your insurance carrier require a referral? Yes () No ()

Does your insurance carrier require a referral? Yes () No ()

EMERGENCY INFORMATION

Name of a local person not living with you _____ Relationship _____

Address _____ Telephone # _____

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished me by any of the physicians of Proliance Surgeons, Inc. P.S. I authorize any holder of medical information about me to release to HCFA and it's agents or to my other insurance any information needed to determine these benefits. I authorize the treatment of the person named above and agree to pay for all fees and charges for such treatment, and I accept full financial responsibility for non-covered services.

Signature

Date