ACCOUNT NO.: ______________________

ORTHOPAEDIC ASSOCIATES
of Southern Delaware, P.A.

PATIENT REGISTRATION

(PRINT CLEARLY)

Patient Full Name: ______________________ Age: __________ DOB: __________

Social Security No.: ______________________ Sex: __________ Home Phone: ______________________

Address: ______________________ City: ______________________ State: __________

Zip: ______________________ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Patient's Occupation: ______________________

Employer Name & Address: ______________________

City: ______________________ State __________ Work Phone: ______________________

Family Physician: ______________________ Referred By: ______________________

Spouse Full Name: ______________________ Social Security No.: ______________________

Address: ______________________ City: ______________________ State: ______ Zip: __________

Occupation: ______________________ Work Phone: ______________________

Guardian information for minors or caregiver of an incompetent patient:

Guardian Full Name: ______________________ Social Security No.: ______________________

Address: ______________________ City: ______________________ State: ______ Zip: __________

Occupation: ______________________ Work Phone: ______________________ Relationship to patient: __________

INSURANCE INFORMATION

Primary Coverage Carrier Name: ______________________ Group #: __________ ID#: __________

Subscriber Name: ______________________ Effective Date: ______________________

Secondary Coverage Carrier Name: ______________________ Group #: __________ ID#: __________

Subscriber Name: ______________________ Effective Date: ______________________

I acknowledge receiving a copy of the **NOTICE OF PRIVACY PRACTICES** detailing how my medical information may be used and disclosed in compliance with the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and outlining my rights regarding my medical information.
Patient/Guardian Initials Indicating Receipt: __________

PAYMENT AUTHORIZATION

I, ______________________, hereby authorize Orthopaedic Associates of Southern Delaware, P.A. (OASD) to furnish information concerning my present illness. I direct the insurer to pay, without equivocation directly to OASD, all benefits due to them as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photorealistic copy of this authorization will be as valid as the original.

Signature of Patient/Guardian: ______________________ Date: ______________________