PATIENT REGISTRATION FORM

Patient Information:

Patient (Legal) Name: _____

(Preferred Name): _____ **Previous/Maiden Name(s):** _____

Social Security #: _____ **Birth Date:** _____ **Male:** **Female:**

Marital Status: Married _____ **Single** _____ **Divorced** _____ **Widowed** _____ **Separated** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Patients Employer: _____ **Work Phone #:** _____

Primary Care Doctor: _____

Spouse Name: _____ **Spouse Birth Date:** _____ **Spouse Social Security #:** _____

Phone: _____ **Spouse Employer:** _____ **Spouse Work phone #:** _____

Complete this section if patient is under the age of 18 or a student:

Mother's Name: _____ Father's Name: _____

Mother's Social Security #: _____ Father's Social Security #: _____

Address: _____

Mother's DOB: _____ Employer: _____ Work Phone #: _____

Father's DOB: _____ Employer: _____ Work Phone #: _____

Emergency Contact Information:

Name: _____ **Relationship:** _____

Address: _____ **Phone #:** _____

About your insurance: *We will need a copy of ALL insurance cards*

Primary Insurance: _____ **Policy Number:** _____ **Group Number:** _____

Secondary Insurance: _____ **Policy Number:** _____ **Group Number:** _____

If Medicaid, Passport provider: _____

WORKERS COMPENSATION INJURY? **Yes** **No** **Date of Injury:** _____-_____-_____

AUTO ACCIDENT? **Yes** **No** **Date of Loss:** _____-_____-_____ **OTHER INJURY** **Yes** **No** **Date of Injury:** _____-_____-_____

IF YOU ANSWERED "YES" TO EITHER WORK COMP OR AUTO ACCIDENT PLEASE SEE THE BACK OF THIS FORM FOR OTHER REQUIRED INFORMATION NEEDED TO PROCESS YOUR CLAIM

IMPORTANT INFORMTATION - PLEASE READ:

I authorize the following individual(s) to access my account and medical record information as a personal representative which includes communications, decisions and records: ☐ **Medical Records** ☐ **Account & Billing**

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I acknowledge that I have received or have been offered a copy of the Flathead Valley Orthopedic Center, P.C. Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Flathead Orthopedics may disclose and use my protected health information. I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

Please note this will be provided upon check-in of appointment

Workers' Compensation:

This information must be completed in order for us to bill for services. If it is not complete, the patient will be responsible for full payment at the time they are treated.

EMPLOYER AT TIME OF INJURY: _____ **Phone #:** _____

ADDRESS: _____
STREET ADDRESS *CITY* *STATE* *ZIP*

SUPERVISOR: _____ **PART OF BODY INJURED:** _____ **L R**

In detail, explain how accident/injury occurred?

_____

_____

_____

_____

DATE OF INJURY: _____ **LAST WORKED DATE:** _____

WORK COMP INSURANCE CARRIER: _____

WORK COMP CARRIER ADDRESS: _____
STREET ADDRESS *CITY* *STATE* *ZIP*

Does your work comp carrier require you to make co-payments to the Doctor? Yes No

CLAIMS EXAMINER: _____ **PHONE #:** _____

CLAIM #: _____

Auto Accident:

POLICY HOLDER: _____

CLAIM #: _____ **ACCIDENT DATE** _____

INSURANCE AGENCY: _____

ADDRESS: _____
STREET ADDRESS *CITY* *STATE* *ZIP*

AGENT: _____ **PHONE #** _____

Other Injury:

PLEASE EXPLAIN:

_____

_____

_____

_____

_____

_____

Flathead Valley Orthopedic Center, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.