REGISTRATION

DATE _____

PATIENT _____
LAST NAME FIRST NAME MIDDLE INITIAL

HOME PHONE _____ EMAIL _____

CELL PHONE _____ PERMISSION TO: TEXT | ○ YES ○ NO EMAIL | ○ YES ○ NO

STREET ADDRESS _____ SOCIAL SECURITY NO. _____

CITY _____ STATE _____ ZIP _____ BIRTHDAY _____ AGE _____

RACE _____ ETHNICITY _____ ○ MALE ○ FEMALE

ATTORNEY _____ ATTORNEY PHONE _____

HOW WOULD YOU LIKE TO RECEIVE YOUR BILLING STATEMENTS? ○ PAPER ○ EMAIL ○ TEXT

EMPLOYER

EMPLOYER NAME _____ JOB TITLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ PHONE _____

PATIENT INSURANCE INFORMATION

INSURED'S NAME _____
LAST NAME FIRST NAME MIDDLE INITIAL

PHONE NUMBER _____

RELATIONSHIP TO INSURED ○ SELF ○ SPOUSE ○ CHILD ○ OTHER

CONDITION RELATED TO ○ ILLNESS ○ EMPLOYMENT ○ AUTO ○ OTHER

INSURED/SUBSCRIBER NAME _____ SOCIAL SECURITY NO. _____

INSURANCE ID NO. _____ INSURED'S DATE OF BIRTH _____

INSURANCE COMPANY NAME _____

ADDRESS/PHONE _____ CLAIM NO. _____

POLICY NO. _____ EFFECTIVE DATE _____

REFERRAL

HOW WERE YOU REFERRED TO THE OFFICE?

○ BY A PATIENT-NAME _____ ○ BY A PHYSICIAN-NAME _____

○ INSURANCE PLAN ○ EMPLOYER ○ INTERNET ○ RADIO ○ OTHER _____

PATIENT AGREEMENT

I, the undersigned, have insurance coverage with _____ (INSURANCE COMPANY) and assign directly to the ***Ohio Sports & Spine Institute LTD***., providers all my medical benefits, if any, otherwise payable to me for services rendered. I understand that I am fianancially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

SIGNATURE OF INSURED/GUARDIAN DATE