FREEMAN SPINE & ORTHOPEDIC MEDICINE

REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ M.I.: _____ Date: _____
Home Address:_____ City: _____ State: _____ Zip: _____
Home Phone: _____ Social Security: _____ Sex: _____ Date of Birth: _____
Age: _____ Marital Status: _____ Spouse's Name: _____
Employer: _____ Occupation: _____
Work Phone: _____ Cellular Phone: _____ E-Mail Address: _____
Referring Doctor: _____ Address: _____ Phone: _____
Primary Care Doctor: _____ Address: _____ Phone: _____
How were you referred:_____
Emergency Contact: _____ Phone: _____ Relationship:_____

Insurance Information

Primary Insurance Company: _____ HMO / PPO / POS
Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Policy / Group Number: _____
Insurance Phone: _____ Policy Holder DOB: _____ Policy Holder SS#:_____
Relationship to Insured: ____Self, ____Spouse, ____Child
Secondary Insurance Company: _____ HMO / PPO / POS
Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Policy / Group Number: _____
Insurance Phone: _____ Policy Holder DOB: _____ Policy Holder SS#:_____
Auto / Workers Comp Injury: _____ Claim Number: _____ Accident Date: _____

Assignment of Benefits / Financial Responsibility

*****PLEASE PROVIDE US WITH COPIES OF ALL INSURANCE CARDS*****

I hereby authorize FREEMAN SPNE & ORTHOPEDIC MEDICINE (FSOM) to furnish information to insurance companies or other physicians concerning my illness and treatments, and I hereby assign FSOM all payments for medical services rendered to me or my codependents. I hereby authorize FSOM to provide diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the attending physician to myself or minor children named above. Necessary forms will be completed to expedite insurance carrier payments, but I hereby acknowledge that I am responsible for all fees, regardless of insurance coverage. I agree to pay for services when rendered unless other arrangements have been made in advance and my failure to do so may result in additional fees to include attorney's collections and others as allowable by law. I/we authorize payment of medical benefits to FSOM. I hereby further agree to guarantee payment to FSOM. for myself or any of my dependents. I agree to pay a $30.00 No Show fee should I miss a scheduled appointment. If I provide a credit / debit card, in written or verbal form, I give FSOM authorization to charge my account for any outstanding balance. This is a lifetime authorization.

Patient / Responsible Party Signature: _____ Relationship: _____ Date: _____