ZEHR CENTER ORTHOPAEDICS, P.A.

PATIENT REGISTRATION

***PATIENT INFORMATION*: Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed **Gender:** ☐Male ☐Female

Full Legal Name_____ Date of Birth_____
LAST FIRST MI
Social Security#_____ E-Mail Address_____

Local Address _____Unit_____City_____ State_____Zip_____

Alternate Address _____Unit_____City_____ State_____Zip_____

Local Phone [ ] _____ Cell Phone [ ] _____ Alternate Phone [ ] _____

PATIENT EMPLOYMENT INFORMATION:

Company _____ Address _____ Work Phone [ ] _____

PATIENT INSURANCE INFO: **[PLEASE PRESENT INSURANCE CARD[S] & DRIVER'S LICENSE]**

Primary Insurance Company Name_____

Insurance ID#_____Group#_____

Medical Claims Address_____

Subscriber Information [Please complete unless patient is subscriber]

Name_____Relationship to Patient_____

Date of Birth_____ Social Security#_____

Secondary Insurance Company Name_____

Insurance ID#_____Group#_____

Medical Claims Address_____

Subscriber Information [Please complete unless patient is subscriber]

Name_____Relationship to Patient_____

Date of Birth_____ Social Security#_____

PATIENT REFERRAL INFORMATION:

○ SELF ○ FRIEND ○ WEBSITE ○ PHONEBOOK ○ NEWSPAPER ○ MAGAZINE ○ OTHER_____

EMERGENCY CONTACT: Name _____
LAST FIRST MI
Address_____Unit_____City_____ State_____Zip_____

Home Phone [ ] _____ Cell Phone [ ] _____Work Phone [ ] _____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to ZEHR CENTER for ORTHOPAEDICS, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ **Signature** _____