Name:
DOB:
Acct #:
Age:
Date:

Orthopaedics
OF STEAMBOAT SPRINGS

Patient Registration

Section I **Patient Information** **Date** _____

Last Name: _____ First: _____ M.I. _____ I prefer to be called: _____

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

Daytime Phone _____ Work Phone _____ Cell Phone _____

Race _____ **Ethnicity** ☐ Hispanic ☐ Non-Hispanic ☐ Other

Date of Birth: _____ Social Security Number: _____ ☐ Male ☐ Female

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse or Parent's Name: _____ Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Patient Email Address: _____ Patient Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Section II **Insurance Information**

Name of Insured _____ DOB _____ Relationship to Patient _____

Name of Employer: _____ Insurance Company _____

---------- **DO YOU HAVE ANY ADDITIONAL INSURANCE?** ☐ **Yes** ☐ **No** **IF YES, COMPLETE THE FOLLOWING**

Name of Insured _____ DOB _____ Relationship to Patient _____

Name of Employer: _____ Insurance Company _____

Section III **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

****If this is a work comp claim, provide the needed billing information. If we don't receive this, payment by your work comp agency may be denied and you will be responsible for payment!**

Section IV **Work Comp or Auto Insurance Information**

Name of Auto or Work Comp Insurance _____ Date of Injury: _____

Name of Adjuster: _____ Adjuster's Phone Number: _____

Claim #: _____ Describe how the injury occurred. _____

** By signing this form, I authorize payments of any insurance benefits for health care services be made directly to *Orthopaedics of Steamboat Springs*. **Note**: If patient is a minor, this form must be signed by a parent or legal guardian.

I understand that I am responsible for any portion of fees not paid by an insurance company or other coverage plan. FC2

Patient/Guardian Signature _____ Date _____