



Shore Orthopedic Associates

... a division of Shore Health Services, Inc.®

PATIENT REGISTRATION

Account # _____

NAME (First/Middle/Last): _____ SINGLE / MARRIED / WIDOWED / DIVORCED

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

911 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____

GENDER: M F DATE OF BIRTH: _____ AGE: _____ SS#: _____

OCCUPATION: _____ EMPLOYER: _____ TEL#: (_____) _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE / PARENT / GUARANTOR INFORMATION

Name: _____ Phone: (_____) _____

Employer: _____ Phone: (_____) _____

Date of Birth: _____ SS#: _____ Relationship: _____

WHO IS RESPONSIBLE FOR YOUR MEDICAL BILLS? Please circle one.

Insurance (A copy will be filed in your medical record) Self Workman's Compensation Other: _____

Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Telephone #: _____

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY OR IF WE CANNOT REACH YOU?

Name: _____ Relationship: _____

Home Phone #: (_____) _____ Work Phone #: (_____) _____

Answering Machine _____ Employment _____ Other _____

DO YOU HAVE AN ADVANCE DIRECTIVE? I.e. Living Will or a Durable Power of Attorney ____ YES ____ NO

If not, would you like information on Advance Directives? ____ YES ____ NO

WHAT PHARMACY DO YOU USE? Please circle one: Cheriton CVS Cape Charles Rayfield's Nassawadox
Rayfield's Exmore Rite Aid H&H Onley Rite Aid Runnigers Onancock / Parksley Walmart

WHO IS YOUR PRIMARY CARE DOCTOR? _____ YOUR REFERRING DOCTOR? _____

AUTHORIZATION FOR TREATMENT: I hereby give permission to the health care providers of Shore Orthopedic Associates and any assistants to administer treatment, medication or diagnostic testing that they may deem advisable in the care and treatment of my case. Authorization is given to Shore Orthopedic Associates and any assistants to contact the patient's employer or insurer regarding existing coverage of patient's insurance(s). I understand that Shore Orthopedic Associates will release financial, medical and other such information in accordance with Federal Law (HIPAA) as explained in the Patient Notice of Privacy Practices booklet. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Shore Orthopedic Associates and of my rights with respect to my health information. ____ I have received. ____ I have been offered and refused.

I authorize the release of any medical information necessary to process insurance claims and request that payment of benefits be made to Shore Orthopedic Associates. I understand that if I am referred to another doctor or for diagnostic testing, it is my responsibility to obtain an insurance referral. I understand that I am financially responsible for all charges for services rendered by the health care provider. Even though I may carry health insurance, I understand that I will be responsible for any charges that are not covered by my health insurance policy. I understand that my co-pay is to be paid at the time of service.

Patient or Responsible Party Signature: _____ Date: _____

Briefly explain why the patient was not able or willing to sign this form. _____

REGARDING MINORS:

I, _____, give Shore Orthopedic Associates permission to treat my child, _____.

I give _____ permission to escort my child during treatment.

Parent or Guardian Signature: _____ Date: _____

Verbal Authorization Witness #1 _____ Date: _____ Witness #2 _____ Date: _____