REGIONAL ORTHOPEDIC Professional Association
WWW.ROPANJ.COM
PHONE 856-663-7080
FAX 856-663-4945

REGIONAL RENEW
WWW.REGIONALRENEW.COM
PHONE 856-675-3380
FAX 856-406-6646

PATIENT REGISTRATION FORM

HEIGHT WEIGHT DATE OFFICE

LAST NAME FIRST NAME MIDDLE INITIAL

STREET CITY STATE ZIP

SS# DATE OF BIRTH: AGE: SEX: MARITUL STATUS:

HOME PHONE#: WORK PHONE#: CELL PHONE#:

EMPLOYER NAME OCCUPATION

SPOUSE'S NAME SPOUSE'S SS#:

IS PATIENT A MINOR? _____YES _____NO IF YES, GUARDIAN'S FULL NAME:

GUARDIAN'S ADDRESS:

GUARDIAN'S SS# GUARDIAN'S PHONE # (IF DIFFERENT FROM ABOVE):

PHYSICIAN INFO

FAMILY PHYSICIAN'S FULL NAME: PHONE#:

ADDRESS: FAX#:

WHO REFERRED YOU TO OUR OFFICE,NAME: PHONE#:

ADDRESS: FAX#:

REASON FOR VISIT

_____ AUTO ACCIDENT_____ AUTO ACCIDENT WORK RELATED _____AT WORK_____AT HOME_____OTHER'S PROPERTY_____OTHER

DATE OF ACCIDENT: DID YOU FILE AN ACCIDENT REPORT:_____YES _____NO

DID YOU GO TO A HOSPITAL OR EMERGENCY ROOM?: ____ YES ____ NO IF YES, WHERE?:

WHAT TESTING/TREATMENT DID YOU HAVE?: _____XRAY _____MRI _____CT SCAN _____OTHER IF OTHER, EXPLAIN:

BILLING AND INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE:

ID# GROUP#

INSURED'S NAME: SS #: DOB:

SECONDARY HEALTH INSURANCE:

ID# GROUP#

INSURED'S NAME: SS #: DOB:

IF AUTO OR WORK RELATED, PLEASE COMPLETE NEXT SECTION:

AUTO: INSURANCE CO. NAME: INSURED'S NAME:

ADDRESS:

CLAIM #: ADJUSTER: PHONE #:

WORK RELATED: INSURANCE CO. NAME: INSURED'S NAME:

ADDRESS:

CLAIM #: ADJUSTER: PHONE #:

DO YOU HAVE AN ATTORNEY _____YES _____NO

ATTORNEY NAME: PHONE #:

ADDRESS:

IN THE EVENT THAT COLLECTION OF THIS BILL BECOME NECESSARY, YOU AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL ATTORNEY FEES PLUS COSTS INCURRED BY REGIONAL ORTHOPEDICS IN CONNECTION WITH SUCH COLLECTION.

I IRREVOCABLY ASSIGN TO REGIONAL ORTHOPEDIC PA ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACT FOR PAYMENT OF SERVICES RENDERED TO ME.

I AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIM TO BE RELEASED TO REGIONAL ORTHOPEDIC, PA.
THE ABOVE HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND IT'S NATURE AND EFFECT AND EXERCISE IT VOLUNTARILY.

PATIENT SIGNATURE:_____ DATE:_____ TAKEN BY:_____