

URQUHART ORTHOPEDIC ASSOCIATES, P.A.  
PATIENT REGISTRATION FORM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_  
City State Zip Code

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Marital Status: Single Married Divorced Widow Other

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Card Holder Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_

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Retired? Yes No Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone # \_\_\_\_\_

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Referred by \_\_\_\_\_ Address \_\_\_\_\_

Phone # ( ) \_\_\_\_\_

Primary Care MD \_\_\_\_\_ Address \_\_\_\_\_

Phone # ( ) \_\_\_\_\_

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Person to contact Relationship to  
in case of emergency \_\_\_\_\_ Patient \_\_\_\_\_

**Is this person authorized to discuss your medical condition with us?** Yes No

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

If Patient is a Minor  
Parent/Legal Guardian \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_  
State Zip Code

Parents Date of Birth \_\_\_\_\_ Parents Social Security # \_\_\_\_\_

PAYMENT POLICY

All Medicare, Auto, Private Health claims are submitted as assigned claims. You will be responsible for co-payments, co-insurance or deductibles. All office visit copays are due the day of your visit. It is the patient's responsibility to obtain and maintain a valid referral for all appointments. If you do not have a valid referral, we will have to reschedule your appointment.

Authorized workman's compensation claims will be submitted directly to the carrier for payment.

By signing this policy, I am authorizing all insurance payments, including Medicare & medigap payments for medical services rendered to myself or my dependents to the physicians of Urquhart Orthopedic Associates

I also authorize Dr. Urquhart to furnish and disclose information concerning my illnesses and treatments to the insurance carriers to facilitate payment for services; to other medical care providers to coordinate my care; and, in the case of accident related treatment to insurance carriers, their adjusters, nurse case managers, and attorneys.

SIGNATURE

DATE

Primary Insurance Name: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

WORKMAN'S COMPENSATION INSURANCE:

Insurance Company \_\_\_\_\_

Claims Address \_\_\_\_\_

Claim # \_\_\_\_\_ Date of Injury/Accident \_\_\_\_\_

Adjuster Name \_\_\_\_\_ Adjuster Phone # \_\_\_\_\_

Nurse Case Mgr Name \_\_\_\_\_ Phone # \_\_\_\_\_

MOTOR VEHICLLE INSURANCE:

Insurance Company \_\_\_\_\_

Claims Address \_\_\_\_\_

Claim # \_\_\_\_\_ Date of Injury/Accident \_\_\_\_\_

Adjuster Name \_\_\_\_\_ Adjuster Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_