



NEW ENGLAND  
ORTHOPEDIC SURGEONS

300 Birnie Avenue, Suite 201 • Springfield, MA 01107-1107  
(413) 785-4666 • www.neortho.com

Date: \_\_\_\_\_  
Patient ID No.: \_\_\_\_\_

**PATIENT REGISTRATION INFORMATION**

**PATIENT INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ M.I.: \_\_\_\_\_  
IF MINOR, RESPONSIBLE PARTY IS: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ SEX (M/F) \_\_\_\_\_ SSN: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
EMPLOYER/SCHOOL: \_\_\_\_\_  
PRIMARY CARE PHYSICIAN: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
ONSET OF SYMPTOMS: \_\_\_\_\_ REASON FOR VISIT: \_\_\_\_\_  
IS THIS RELATED TO:      WORKERS' COMP     YES     NO      AUTO     YES     NO

**INSURANCE INFORMATION**

**PRIMARY INS. CO. (NAME):** \_\_\_\_\_  
INSURANCE BILLING ADDRESS: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
INSURANCE PHONE NUMBER: \_\_\_\_\_ INSURANCE ID #: \_\_\_\_\_  
GROUP #: \_\_\_\_\_ POLICY DATES – FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**\*\*\*COMPLETE THE REQUIRED INSURANCE POLICY HOLDER INFORMATION\*\*\***

NAME: \_\_\_\_\_ SEX (M/F): \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
RELATION TO POLICY HOLDER: \_\_\_\_\_ POLICY HOLDER SSN: \_\_\_\_\_  
POLICY HOLDER ADDRESS: \_\_\_\_\_  
EMPLOYER NAME: \_\_\_\_\_

**SECONDARY INS. CO. (NAME):** \_\_\_\_\_  
INSURANCE BILLING ADDRESS: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
INSURANCE PHONE NUMBER: \_\_\_\_\_ INSURANCE ID #: \_\_\_\_\_  
GROUP #: \_\_\_\_\_ POLICY DATES – FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**\*\*\*COMPLETE THE REQUIRED INSURANCE POLICY HOLDER INFORMATION\*\*\***

NAME: \_\_\_\_\_ SEX (M/F): \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
RELATION TO POLICY HOLDER: \_\_\_\_\_ POLICY HOLDER SSN: \_\_\_\_\_  
POLICY HOLDER ADDRESS: \_\_\_\_\_  
EMPLOYER NAME: \_\_\_\_\_

**IF ACCIDENT RELATED**

WORKER'S COMP/AUTO/OTHER: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

WORKER'S COMP/AUTO/OTHER CLAIM NUMBER: \_\_\_\_\_

WORKER'S COMP/AUTO/OTHER INSURANCE CARRIER: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

**ATTORNEY INFORMATION**

NAME OF ATTORNEY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

**AUTHORIZATIONS****AUTHORIZATION TO RELEASE INFORMATION**

I give permission to NEOS to disclose my Protected Health Information to the following individual(s). I hereby understand this listing remains in effect unless revoked by me in writing.

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**EMERGENCY CONTACT IF DIFFERENT FROM INDIVIDUALS LISTED ABOVE**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

I give permission to New England Orthopedic Surgeons to leave information and instructions on my answering machine.

I hereby understand and give permission for disclosure, during my examination only, of my Protected Health Information to any individual I allow to accompany me into the examination room. I also understand by providing my email address I am allowing transmittal of my Protected Health Information.

I acknowledge that I have received a copy of New England Orthopedic Surgeons Notice of Privacy Practices.

I hereby authorize New England Orthopedic Surgeons, Inc. to release information acquired in the course of my examination and/or treatment to my primary care physician, a consulting physician, and my health insurance carrier as part of the normal process in the delivery of health care.

**CLOSE RELATIVE NOT RESIDING WITH YOU**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**

I hereby authorize payment directly to New England Orthopedic Surgeons for all medical/surgical benefits, if any, otherwise payable to me under the terms of my health insurance policy.

**STATEMENT OF FINANCIAL RESPONSIBILITY**

I am responsible for any deductible or co-payment designated by my insurance. I am responsible for any non-covered services, including durable medical equipment, as well as obtaining and maintaining a current referral. I fully understand that I am responsible to pay for services rendered, including reasonable attorney's fee and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 12%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

I HAVE VERIFIED THE ACCURACY OF ALL INSURANCE AND DEMOGRAPHIC INFORMATION WHICH I PROVIDED AT REGISTRATION. I AGREE THAT ALL OF THE ABOVE AUTHORIZATIONS ARE VALID INDEFINITELY UNLESS OTHERWISE STATED.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the signature above is not the patient's, please state your relationship to the patient: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_