



NEW ENGLAND
ORTHOPEDIC SURGEONS

300 Birnie Avenue • 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: _____
NAME OF EMPLOYER/SCHOOL: _____
PRIMARY CARE PHYSICIAN: _____ ADDRESS: _____
REFERRED BY: _____ ADDRESS: _____
ONSET OF SYMPTOMS/INJURY: _____ REASON FOR VISIT: _____
IS THIS RELATED TO: WORKERS' COMP YES NO AUTO YES NO
IF YES PLEASE FILL OUT ACCIDENT AND ATTORNEY INFORMATION ON BACK

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 _____
(other than patient)

NAME _____ PHONE _____ RELATIONSHIP _____
(other than patient)

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: _____