Connecticut Orthopaedic Specialists

Registration Form

PATIENT INFORMATION

Patient's Name: _____ Phone: Home ( ) _____ Cell ( ) _____

Patient's Address: _____
street city state zip

DOB: _____ Sex: _____ Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security: _____ Employment Status: ☐ Employed ☐ Part-Time ☐ Full-Time Student

Primary Care Physician: _____ City: _____ Phone: ( ) _____

Referring Physician: _____ City: _____ Phone: ( ) _____

Current Employer: _____ Occupation: _____ Work Phone: ( ) _____

Employer's Address: _____
street city state zip

_____ _____ ( ) _____
Father's Name if patient is a minor | Address (if different than patient) | Work Phone

_____ _____ ( ) _____
Mother's Name if patient is a minor | Address (if different than patient) | Work Phone

INSURANCE

Primary Insurance Name: _____ Group #: _____ ID #: _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Subscriber's Employer: _____ Work Phone: ( ) _____

Employer's Address: _____
street city state zip

Patient's relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Name: _____ Group #: _____ ID #: _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Subscriber's Employer: _____ Work Phone: ( ) _____

Employer's Address: _____
street city state zip

Patient's relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

ACCIDENT INFO

Were you injured in an accident? ☐ Yes ☐ No If Yes? ☐ Work ☐ Auto ☐ Other: _____

Name of Work/Auto/Liability Insurance: _____

Insurance Address: _____
street city state zip

Date of Accident: _____ Claim/Case# : _____

Claim Adjuster: _____ Phone: ( ) _____ Fax: ( ) _____

Attorney's Name: _____ Phone: ( ) _____ Fax: ( ) _____

Attorney's Address: _____
street city state zip

If Work, Employer at time: _____ Phone: ( ) _____

Employer's Address: _____
street city state zip

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize payment of insurance benefits to be made directly to Connecticut Orthopaedic Specialists, P.C., and understand that I am financially responsible for payment to Connecticut Orthopaedic Specialists, P.C. for charges related to services provided to or incurred by me or my dependents, including items not covered by my insurance. I agree to pay a service charge to COS in the event I provide a check which is not honored by my bank and returned for "insufficient funds".

Signature _____ Date _____

ACKNOWLEDGEMENT OF HIPAA / NOTICE OF PATIENT PRIVACY AND HEALTH

I have received the notice of Use and Disclosure of Protected Information. I understand this notice and have had the opportunity to ask questions regarding any concerns. I hereby authorize the release of information to others as needed for COS to receive payment.

Signature _____ Date _____

Rev. 12/21/2011