PATIENT REGISTRATION FORM (please print)

Orthopaedic Surgical Associates, LLC
JIMMY M TAMAI, MD
DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
Steese Medical Center
1275 Sadler Way
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Fairbanks, AK 99701
P: 907-374-4463
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office@tamaiosa.com

Patient Name _____
Preferred/Nickname _____
SS # _____
Birth Date _____
DL# _____

Is patient a minor? Yes ____ No ____ RESPONSIBLE **PARTY/GUARANTOR** (**must be present**) _____

Mailing Address _____
(City) (State) (Zip)
Physical Address _____
(City) (State) (Zip)
E-mail Address _____ **Consent to send/receive information through e-mail:** Yes____ No____

Cell Phone ( ) _____ **Consent to send/receive information through text:** Yes____ No____
Home Phone ( ) _____ **Alternative Phone** ( ) _____

Marital Status: Married Single Other **Sex**: Male Female Gender: _____

Spouse/Partner _____ **Employer** _____ **Phone** _____

Primary Care Physician _____ **Who referred you to us?** _____

Employer _____ **Occupation** _____ **Phone** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

#1 PRIMARY INSURANCE INFORMATION: ☐ Card on file
Insurance Company Name _____ Phone ( ) _____
Insurance Company Address _____
Policy Holder Name _____ SSN _____ Birth Date _____
Relationship _____ Group # _____ ID # _____

#2 SECONDARY INSURANCE INFORMATION: ☐ Card on file
Insurance Company Name _____ Phone ( ) _____
Insurance Company Address _____
Policy Holder Name _____ SSN _____ Birth Date _____
Relationship _____ Group # _____ ID # _____

WORKERS COMPENSATION
Insurance Company Name _____ Employer _____
Claim # _____ Date of Injury _____ Body Part Injured _____
Adjuster Name _____ Phone( ) _____ Fax ( ) _____

I understand that I am fully responsible for any and all charges for services rendered by the Orthopaedic Surgical Associates. If insurance information is provided; my insurance company will be billed as a courtesy to me. I am responsible for my portion of the bill at the time that services are rendered. I hereby authorize payment under my insurance to be paid directly to Orthopaedic Surgical Associates and I further authorize release of any information necessary to my insurance company for payment of claims.
I, the undersigned hereby authorize Orthopaedic Surgical Associate providers to examine me, to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary.
For Treatment of a Minor: I hereby authorize the medical providers of Orthopaedic Surgical Associate to give my minor son/daughter treatment that he/she may need.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I, _____, acknowledge and agree that I have received a copy of ORTHOPAEDIC SURGICAL ASSOCIATES, LLC. Notice of Privacy Practices.
(Print Name)

Patient/Guarantor Signature _____ **Date** _____