Tobin Bone and Joint Surgery, Inc.   New Patient Registration

____
Patient last name   first name   middle   maiden name

Permanent mailing address:____
____

Street address: ____
(if different)
Home Phone: (______)____________Work phone: (____)_________ Cell phone (____)________
Email:__________________
Local address: ____
(if different)
Local Phone: ________________ Drivers License number: ______________________________
(State)   (number)
Soc. Sec. number: ______________________ Birth date: ______________

Employer's name: ____
Your position: ____
Employer's address: ____
______________________________Employer's phone: (_______)_________________________

Emergency contact: Name:____
Phone: (_______)____________________
Address:____
____
Your relationship to this person: ____

If Patient is under age 21 or under age 26 (using parent's insurance), or not the guarantor, please complete the following:
Relationship to patient (circle one): Mother Father Guardian – must be parent's info for the parent who is named on the insurance card.

____
(last name)   (first)   (middle)   (maiden)
Address: ____
Home phone: (_______)________________ Work phone: (______)____________________
Soc. Sec. Num.: _______________ Drivers License:state:_____number:__________________
Cell phone:(_____)___________ Email:______________________ Parent birthdate:__________
Employer's name: ____
Employer's address: ____

If parents have separated addresses pls. Provide second parent's name:____________________
Address: ____Phone: (____)________________

Primary Insurance (please provide us with a copy of your insurance card)
Company: ______________________________ Insured's name: ____________________
Identification number: __________________________________ Phone: __________________

Secondary Insurance (please provide us with a copy of your insurance card)
Company: ______________________________ Insured's name: ____________________
Identification number: __________________________________ Phone: __________________

If you were referred here please tell us by whom: ____________________________________

Is your visit due to injuries sustained in an auto accident? Yes____ No ______
Auto Ins. Co. responsible for medical bills: ____________________________________
Name of insurance representative or contact: __________________________________
Phone number: ______________________
Claim number: ______________________ Policy number: ______________________

Is your visit due to injuries sustained at your employment? Yes _____ No _____
If so, please provide: Name of Employer: ____________________________________
Employer contact and phone: ____
Address of Employer: ____
Worker's compensation Insurance information: ___________________________________
(Ins. Co. name)
Name of insurance representative or contact: ____________________________________
Phone number of Ins. Co. contact: _________________________
Date of injury: _____________ Date injury reported to employer: _____________ To whom did you report the injury? __________________________________ Claim number: ______________

If you have an attorney representing you with respect to your injuries please provide:
Attorney name: __________________________ Address: ___________________________
____ Phone: ______________________________

I hereby authorize payment be made directly to Tobin Bone and Joint Surgery, Inc.("TB&J") for their services by my insurance carrier, Worker's compensation carrier, or Auto Insurance of benefits otherwise payable to me. I further authorize direct payment of benefits under Title 19 of the Social Security Act to TB&J in a claim related to injuries for which medical services are provided to me by TB&J whether categorized as damages, medical fees or otherwise. I understand and agree that I am financially responsible to TB&J for all charges not covered by this assignment of benefits, unless prohibited by law. Should timely payments of this account not be made, I authorize TB&J. to retain the services of an attorney and/or collection agency and agree to reimburse the collection fees which may be based upon a percentage at a maximum of 33% of the debt, and all costs, expenses, including reasonable attorney fees. Any expenses incurred by such action shall become an additional liability for which I assume responsibility. Additionally, I understand that interest at the rate of 1.5% per month will be added to any balances past due after 60 days. I further authorize the release to any insurance company, health care facility or agency, or to the court in case of legal action, such information as may be necessary for the completion of my claim or to otherwise secure payment for medical services rendered. I also authorize the release of medical information regarding my case to other consulting and/ referring health care professionals. I permit a copy of this authorization to be used in place of the original.
Payment is due at the time of service unless other arrangements have been made in advance

____
Signature Date

TOBIN BONE and JOINT SURGERY, INC.
JOSEPH P. TOBIN, MD, FAAOS
Board Certified Orthopaedic Surgeon

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:______________________

Today's Date:________________

I acknowledge Tobin Bone and Joint Surgery, Inc.'s Notice of Privacy Practices has been made available to me to read. This Notice describes how medical information about me may be used and disclosed and how I can get access to this information. It describes information about privacy practices followed by employees, staff and other office personnel of Tobin Bone and Joint Surgery, Inc.

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Patient's signature

____

Signature of Parent or Guardian if Patient is a minor

____

Signature of Patient's Personal Representative if Patient is not signing

____

Printed Name of Person signing if other that the Patient (e.g. Personal Representative of Patient or Patient's Parent or Guardian)

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