Dr. Jon P. Kelly, M.D

Please Print

Patient Registration

Patient Name	Last	First	Middle
Home Address	City	State	Zip	Home Phone Number

Social Security Number	Date of Birth	Age	Sex	Marital Status	Cell Phone

Employer	Occupation	Work Phone

Referring Physician (Name, Address, Phone)	Primary Care Physician

Emergency Contact Information

Name	Relationship To Patient	Phone
Address	City	Zip

Primary Insurance Information

Insurance Company	Phone
Insurance Company Address	

Subscriber's Name	Date of Birth	Subscriber's SS#	Relationship to Patient
Group Number		ID or Policy Number	Effective Date

Secondary Insurance Information

Insurance Company	Phone
Insurance Company Address	

Subscriber's Name	Date of Birth	Subscriber's SS#	Relationship to Patient
Group Number		ID or Policy Number	Effective Date

Work Related Injuries Only / Complete the following

Compensation Insurance Carrier	
Insurance Company Address	Phone

Date of Injury	Was Injury Report Filed?	Name of Insurance Adjuster	Adjuster Phone Number

Please Read Carefully

In order to provide you with the highest quality of aforadable healthcare, we request that our charges for office visits be paid at the conclusion of each visit. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, others pay a percentage of the charge. It is your responsibility to pay any co-insurance, or any other balance not paid for by your insurace. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. The the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to the provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all necessary information to secure payment. Carlsbad Orthopaedic Group physicians may have a financial or other interest in companies which manufacture or distribute some of the products that are used in the Carlsbad Orthopaedic Group facility. If you have questions or concerns about a particular product or manufacturer, please let your physician know.

Signature (Responsible Party):______________________________ Date:______/______/______ Acct#________________

New Patient [ ] Update [ ]

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