Insurance Cards copied ___ **Provider** ________________

Date: Acct#

Front Range Orthopaedics
PATIENT REGISTRATION FORM

(Please Print and Complete All Sections Below)

Referring Physician:	Primary Care Physician:

PATIENT INFORMATION

Last name:	First:	Middle initial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone#	Cell Phone #	Work phone#	Birth date: / /	Age:	Sex: ❑ M ❑ F

Address (street, city, state, zip code):	Spouse's Name:

Occupation:	Employer:	Employer phone # ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Home phone # (if different): Work phone #

Relationship to patient: ❑Self ❑Spouse ❑ Parent ❑Other:

Occupation:	Employer:	Employer address:	Employer phone # ( )

Primary Insurance:

Subscriber's name:	Subscriber's ID# or SSN	Birth date: / /	Group #	Policy no#	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance:

Subscriber's name:	Subscriber's ID# or SSN	Birth date: / /	Group #	Policy no#	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Is this a **Worker's Comp Claim?** ❑yes ❑no - if yes, please fill out the Worker's Comp Form	Is this an **Auto Insurance Claim?** ❑yes ❑no - if yes, please fill out the Auto Insurance Form

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #	Alternate phone #
		( )	( )

The above information is true to the best of my knowledge. I certify that I am the patient or duly authorized general agent to furnish the information requested. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Front Range Orthopaedics or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*