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 not the guarantor, please complete the following:
Relationship to patient (circle one): Mother Father Guardian

(last name) (first) (middle) (maiden)
Address: _____
Home phone: (____)_____ Work phone: (____)_____
Soc. Sec. Num.: _____ Drivers License:state:____number:_____
Cell phone:(____)_____ Email: _____
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. 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 Tobin Bone and Joint Surgery, Inc for their services. I authorize a medical lien against any funds recovered in a claim related to injuries for which medical services are provided to me by Tobin Bone and Joint Surgery, Inc. whether or not the funds are categorized as damages, medical fees or otherwise. I understand and agree that I am financially responsible to Tobin Bone and Joint Surgery, Inc. 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 Tobin Bone and Joint Surgery, Inc. to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. 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

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.

_____
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)

TOBIN BONE AND JOINT SURGERY, INC.

COORDINATION OF BENEFITS QUESTIONNAIRE

(Primary) INSURANCE PLAN: _____

POLICYHOLDER NAME: _____

GROUP #: _____

MEMBER ID #: _____

Your insurance policy may contain a Coordination of Benefits (COB) provision. This form confirms that you or any other member of this insurance policy does not have another medical or dental insurance policy. If you have any questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your identification card.

- ❑ I am covered by only ONE insurance listed above. I am not covered by any other health insurance policy through my spouse, parent, guardian, or third/other party.
- ❑ I am covered by only ONE insurance listed above.
  This is through my *(check one)*: ❑ Spouse ❑ Parent ❑ Guardian ❑ Third/Other Party
- ❑ In addition to the insurance company listed above, I AM ALSO COVERED BY:

Name of Other Health Insurance Company	Name of Third Party Insurance Company
Health Insurance Policy/ID Number	Third Party Insurance Policy/ID Number
Name of Guardian/Policy Holder	Name of Third Party Insurance Adjuster
Guarantor/Policy Holder Relationship to Patient	Policy Holder Telephone Number
Guarantor/Policy Holder Date of Birth	Date of Injury

PLEASE CHECK ONE:

Is this condition related to:
- ❑ Personal injury
- ❑ Personal illness
- ❑ Work related injury (Third Party Insurance Company)
- ❑ Automobile collision (Third Party Insurance Company)

IF PATIENT IS A DEPENDENT, LIST NAME(S) OF DEPENDENT(S) ON POLICY:

Name	Relationship	Date of Birth	Sex
		/ /	
		/ /	
		/ /	
		/ /	

Printed Name	Signature	Date