PLEASE PRINT

MISSOULA BONE & JOINT

REGISTRATION FORM

PATIENT INFORMATION

Patient Name _____ **Birthdate** _____ Age _____

Mailing Address _____ Home/Cell Phone _____

City/State/Zip _____ Email (optional) _____

Soc. Sec # _____–_____–_____ Marital Status _____ Sex ☐ Male ☐ Female

Occupation _____ Employer _____

Employer's Address _____ Work Phone _____

Spouse's Name _____ DOB _____/_____/_____ Soc. Sec # _____–_____–_____

Employer _____ Work Phone _____

In Case of Emergency Please Contact _____ Phone _____

Referred by _____ Phone _____

Drug Allergies _____

PARENT / GUARDIAN INFORMATION IF PATIENT IS A MINOR

Father/Guardian Name _____ DOB _____/_____/_____ Soc. Sec # _____–_____–_____

Address (if different from patient) _____

City _____ State_____ Zip _____ Home Phone _____

Employer _____ Phone _____

Mother/Guardian Name _____ DOB _____/_____/_____ Soc. Sec # _____–_____–_____

Address (if different from patient) _____

City _____ State_____ Zip _____ Home Phone _____

Employer _____ Phone _____

HEALTH INSURANCE (PLEASE PRESENT YOUR CARD TO RECEPTIONIST)

Primary Insurance _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insured Name _____ Soc. Sec # _____–_____–_____ DOB _____/_____/_____

Policy ID # _____ Group # _____

Secondary Insurance _____

Address _____ City _____ State _____ Zip _____

Insured Name _____ Soc. Sec # _____–_____–_____ DOB _____/_____/_____

Policy ID # _____ Group # _____

ACCIDENT INFORMATION (IF APPLICABLE)

Date of Accident _____ Worker's Compensation ☐ or Auto Accident ☐ or Other ☐

Part of Body Injured _____ Accident Happened in Which State _____

Insurance Carrier _____ Phone _____

Address _____ City _____ State _____ Zip _____

Claim or Policy # _____ Name of Adjuster _____

Employer (if different from above) _____ Phone _____

ASSIGNMENT AND RELEASE OF INFORMATION

NOTE: Insurance Pre-Authorization: It is the patient's responsibility to notify this office if your insurance carrier requires pre-authorization for any services. Assignment and Release of Information: I hereby authorize Missoula Bone & Joint to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician. I understand that I am responsible for any amount not covered by insurance and that if my account is turned over for collections, the fee will be my responsibility. ***By signing below, I recognize and accept responsibility for any balance remaining after payment of benefits.***

☞ _____ _____ _____

Signature of Responsible Party | Relationship to Patient | Date

CONSENT TO TREAT

I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a provider of Missoula Bone & Joint and any employee acting under my provider's orders.

☞ _____ _____ _____

Signature of Responsible Party | Relationship to Patient | Date

OVER ➡