

PATIENT REGISTRATION

PLEASE PRINT

DATE: _____ PHYSICIAN: _____ MRN # _____

Patient Name: _____ Social Security #: _____
 Street Address: _____ Date of Birth: _____
 City, State, Zip: _____ Age: _____ Sex: Male Female
 Home Phone #: _____ Allergies: _____
 Work Phone #: _____ Email Address: _____
 Cell Phone #: _____ Marital Status: Single Married
 Occupation: _____ Widowed Divorced Separated
 Employer: _____ Emergency Contact: _____
 Employer Address: _____ Relationship: _____
 City, State, Zip: _____ Emergency Contact Phone #: _____
 Mother's First Name: _____ Father's First Name: _____

Who referred you (either physician or friend)

Name: _____ Phone #: _____
 Address: _____ City, State, Zip: _____

Primary Care or Family Doctor

Physician Name: _____ Phone #: _____
 Address: _____ City, State, Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____	Secondary Insurance: _____
Insurance Address: _____	Insurance Address: _____
Phone #: _____	Phone #: _____
Identification #: _____	Identification #: _____
Group #: _____ Effective Date: _____	Group #: _____ Effective Date: _____
Policyholder Name: _____	Policyholder Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Policyholder Date of Birth: _____	Policyholder Date of Birth: _____
Policyholder Employer: _____	Policyholder Employer: _____
Policyholder Employer Address: _____	Policyholder Employer Address: _____

If visit is related to an auto accident or worker's compensation claim, please complete:

Name of Insurance: _____ Accident Date: _____
 Address of Insurance Co.: _____ State in which accident occurred: _____
 City, State, Zip: _____ Claims Adjuster Phone #: _____
 Claims Adjuster #: _____ Claim #: _____

LEGAL CASES AND TESTIMONY

We want to acquaint you with our policy related to cases with legal involvement or those requiring testimony. Because of our commitment to clinical care, research and teaching and the ongoing requirements of good patient care, we find it impossible to accept any new patients with legal involvement or cases requiring testimony. It is frequently impossible to predict which case with legal involvement will require testimony and which will not. Therefore, we do not accept any case of this nature and refer patients who need this type of advice and assistance to other physicians for their care.

Our principal reason for declining participation in any case with legal involvement is it would ultimately mean that we would have to deny medical care to other parties. We feel our primary obligation is to render medical care and treatment, rather than testimony and assistance in lawsuits.

I have read and fully understand the above statement. I agree not to require your participation in legal proceedings.

Patient's Signature

Date

Witness' Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I, _____ acknowledge that 3B Orthopaedics, PC has
(please print name)
provided me with a copy of its Notice of Privacy Practices, as required under the Health Insurance
Portability and Accountability Act of 1996.

Patient Signature

Date

3B ORTHOPAEDICS, P.C.

FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND PATIENT AUTHORIZATION

Charges for Items or Services

I am financially responsible, to the extent permitted by applicable law, to pay to 3B Orthopaedics, P.C. (hereafter known as “3B”) all charges for items or services rendered to Patient. This expressly includes any insurance deductibles, co-insurance, co-payments and non-covered services. I acknowledge that the information provided is accurate and complete. If there are any changes to this information in the future, I will provide any such change at my next scheduled visit.

Assignment of Benefits

I hereby authorize and assign payment directly to 3B for medical insurance benefits, including any major medical benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to 3B and its physicians for items rendered to Patient.

Release of Health Information

I authorize 3B to disclose any or all parts of Patient’s medical record to Patient’s insurance company(s) or employer(s) for the purposes of satisfying charges billed by 3B and it’s physicians for items or services provided by to the Patient. I further understand that it may be necessary for 3B to contact my past or present employer(s) in regard to this claim. This authorization does not cover third party liability claims.

I hereby release and forever discharge 3B and its respective employees, directors, officers, shareholders, agents, assigns and legal representatives (collectively, “3B Parties”) from any and all obligations, claims, liabilities, damages, debts, liens and deficiencies arising out of or in connection with 3B’s use or disclosure of my health information in accordance with this Financial Responsibility, Assignment of Benefits and Patient Authorization (“Authorization”). I hereby agree to indemnify and hold harmless the 3B Parties from and against any liability, loss, cost or expense (including reasonable attorneys’ fees) incurred by the 3B Parties in reliance upon this Authorization.

I permit a copy of this Authorization to be used in place of the original. I certify that this information is true complete to the best of my knowledge.

Print Patient Name

Date

Patient Signature

Date

Responsible Party Name (if applicable)

Date

Responsible Party Signature (if applicable)

Date

Please describe Responsible Party’s relationship to Patient and a description of Responsible Party’s authority to act on behalf of the Patient _____

3B Orthopaedics, PC, is an independent medical group affiliated with, but not employed by, Pennsylvania Hospital or the University of Pennsylvania Health System.

(Medicare Patients only Complete Opposite Side)

MEDICARE PATIENTS MUST COMPLETE

Medicare Beneficiary Number: _____

Effective Date Part A: _____ Effective Date Part B: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to 3B to the individual attending physician to for any items or services furnished to me by that physician. I authorize 3B and its physicians to release to the Health Care Financing Administration and its agent any medical information needed to determine these benefits or the benefits for related services.

- 1) Are you receiving Black Lung Benefits? Yes or No (Please circle one)
If yes, Date Benefits Began: _____
- 2) Are the services to be paid by Government Program? Yes or No (Please circle one)
- 3) Are the services to be paid by Veterans Affairs? Yes or No (Please circle one)
- 4) Are the services to be paid by Research Grants? Yes or No (Please circle one)
- 5) Was the illness/injury due to an accident? Yes or No (Please circle one)
If yes, Work related injury/illness? Date: _____
Automobile Accident? Date: _____
Other type of accident? _____ Date: _____
- 6) Are you entitled to Medicare based on Age? Yes or No (Please circle one)
If yes, are you or your spouse currently employed and receiving health benefits through your employer? Yes or No (Please circle one)
Does the patient's employer employ 20 or more employees? Yes or No (Please circle one)
Give approximate number of employees: ____
Does the spouse's employer employ 20 or more employees? Yes or No (Please circle one)
Give approximate number of employees: ____
- 7) Are you entitled to Medicare based on Disability? Yes or No (Please circle one)
If yes, is the patient the dependent of an employed family member? Yes or No (Please circle one)
Are you or your spouse currently employed? Yes or No (Please circle one)
Does the employer employ 100 or more employees? Yes or No (Please circle one)
Give approximate number of employees: ____
Does the employer provide a Group Health Plan? Yes or No (Please circle one).
If yes, please provide copy of Insurance card.
- 8) Are you entitled to Medicare based on End Stage Renal Disease? Yes or No (Please circle one)
If yes, did you receive a kidney transplant? Yes or No (Please circle one)
Date of transplant: _____ Date of first dialysis treatment: _____
Did you participate in a self dialysis-training program? Yes or No (Please circle one)
Date training began: _____
Is the patient within 30-month coordination period? Yes or No (Office Use Only)
- 9) Do you have a secondary insurance to your Medicare plan? Yes or No (Please circle one)

Patient Signature: _____ Date: _____