

PATIENT REGISTRATION FORM

Appt Date _____
Appt Time _____
Doctor ___H___M___G___MT___S

PATIENT INFORMATION

Soc. Sec.# _____ Mr., Mrs., Ms. (Please Circle) DL#: _____
Last Name: _____ First Name: _____ MI: _____
Nickname: _____ Maiden Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Date of Birth: _____ Sex: M F
Marital Status: Single Married Divorced Widowed Legally Separated Other
Race: Caucasian African American Hispanic Hmong Native American Asian Other

In Case of an emergency, contact (not in same household):

Name: _____ Relationship: _____
Home Phone Number: _____ Work Phone Number: _____

RESPONSIBLE PARTY INFORMATION (Only needed if patient is minor or POA is required)

Soc. Sec. # _____ Relationship to Patient: _____
Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Date of Birth: _____ Sex: M F
Marital Status: Single Married Divorced Widowed Legally Separated Other
Race: Caucasian African American Hispanic Hmong Native American Asian Other

PATIENT'S EMPLOYER

Employer Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____ Occupation: _____

INSURANCE INFORMATION

**Please attach a copy – FRONT and BACK –of your insurance card ** If a work excuse is needed, please get at the time of the appointment.

Name of Subscriber (if different than patient): _____
Soc. Sec. #: _____ D.O.B. _____
Subscriber's Employer: _____ Employers Address: _____
Patient's Relationship to insured: Self Spouse Child Other

Do you have any other health insurance: Yes No If yes, please attach a copy – FRONT and BACK of your insurance card

Name of Subscriber (if different than patient): _____
Soc. Sec. #: _____ D.O.B. _____
Subscriber's Employer: _____ Employers Address: _____
Patient's Relationship to insured: Self Spouse Child Other

Green Bay Orthopedics Financial Policy and Patient Signature on File

Payment for all services is the responsibility of the patient. As a courtesy to all our patients, Green Bay Orthopedics LTD will file a claim with your insurance company. However, this is not a guarantee of payment, therefore it is important for you to be aware of your insurance coverage and limitations. Ultimately, financial responsibility for services rendered rests with the patient or his/her family regardless of the nature or extent of insurance coverage. The patient is further responsible for co-payments, deductibles, co-insurance and any balance remaining after receipt of insurance payment.

For your convenience, Green Bay Orthopedics LTD offers the following payment options:

1. Payment in full on the day the service is provided
2. Payment of co-payment, co-insurance or deductible on the day service is provided
3. Payment of co-insurance, deductible or amount denied by insurance upon receipt of statement.

For your convenience, Green Bay Orthopedics LTD accepts cash, personal checks, MasterCard or VISA.

If additional financial counseling is needed please contact the Business Office at 920-430-8120.

I have read, understand and agree to the financial policy as stated above. I hereby authorize payment of medical benefits to Green Bay Orthopedics LTD for any service furnished me by that provider. I authorize physician and clinic to release any information to process insurance claims. This authorization is in effect indefinitely.

Patient Signature: _____ Date: _____

Treatment Authorization for Minors & Incompetents

This form authorizes treatment at Green Bay Orthopedics LTD. I, the Undersigned parent/guardian of _____ (patient's full name), grant permission and authorize medical care and treatment for my above-motined child/ward to Green Bay Orthopedics physicians and staff. This healthcare provider (s) at Green Bay Orthopedics LTD or other persons who act in reliance upon this authorization and medical information.

Parent/Guardian: _____ Date: _____
