BLOUNT ORTHOPAEDIC ASSOCIATES
Patient Registration Form

Patient Information – Please complete entire form and print clearly

Today's Date:	Referring Dr. Name: Telephone ( )	Primary Dr. Name: Telephone ( )
Patient's Last Name:	First Name :	Middle or Maiden
Mailing Address:	City:	State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
SS# :	Date of Birth:	Marital Status: ○ Single ○ Married ○ Widow ○ Divorce Sex: ○ Male ○ Female
Employer Name:	Address:	Occupation:
Person Financially Responsible (if other than patient) Name: SS#: - -	Employer:_____ Phone: ( )	DOB: ____/____/____ Relation:_____
Emergency Contact Name:	Contact Phone: ( )	Relation:

IS THIS VISIT DUE TO AN ACCIDENT?

○ No ○ Yes If yes, date of accident ____/____/____

Where did the accident occur? ○ Work ○ Home ○ School ○ Auto ○ Other: _____

INSURANCE INFORMATION – Please provide a copy of insurance card(s)

Primary Insurance Co. Name	Policyholder's Name: (If other than patient) Employer:	DOB: ____/____/____ Relation:
Insurance Claims Address	City/State/Zip	Insurance Co. Phone ( )
Insured's ID Number:	Group Name and/or Number:	
Secondary Insurance Co. Name	Policyholder's Name: (If other than patient) Employer:	DOB: ____/____/____ Relation:
Insurance Claims Address	City/State/Zip	Insurance Co. Phone ( )
Insured's ID Number:	Group Name and/or Number:	

(see other side)

IMPORTANT FINANCIAL INFORMATION
PLEASE READ AND INITIAL/SIGN

TENNCARE

We do not participate in all TennCare Plans. You are required to see your Primary Care Physician, except in the case of an emergency. You must obtain a referral from your PCP before you can see a specialist or have tests performed. Benefits are declined if this process is not followed and you will be held financially responsible for all medical bills associated with non-compliance with your TennCare Plan. _____ Initial

WORKMAN'S COMP

Requests for Workman's Comp services must be made and pre-authorized by your employer and/or Workman's Comp Carrier case manager. You are responsible for providing us the proper Workman's Comp insurance and claim information so that authorization is obtained for each visit. If, at any time, your Workman's Comp Carrier determines that your injury is not work related, they have the right to deny your claim for all services received. In this case, your medical insurance can be filed, but your will be responsible for any non-covered services, co-pays and/or deductibles. _____ Initial

AUTOMOBILE ACCIDENTS

You, personally, are responsible for services related to an automobile accident. We do not file auto accident claims but will provide you with an itemized statement that can be filed with your Auto Insurance Company or legal representative to do so. _____ Initial

INFORMED CONSENT

I authorize the release of any medical information necessary to process insurance claims by giving permission to use a copy of this signature. I certify that the insurance information I have provided is correct. I authorize payments to be made to Blount Orthopaedic Associates, P.A., on my behalf and I agree to be responsible for payment of Non-covered services, Deductibles, Co-pays, or Out of Network payment reductions. _____ Initial

The undersigned agrees to and understands the financial responsibility for services received.

_____ _____

Signature of Patient or Guardian Date Authorization to release information Date