Calvert Orthopaedics and Sports Medicine Center

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Name: (last, first middle)			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status:
Social Security no.:	Ethnicity:	Race:	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:	City:	State:	Zip Code:		
Occupation:	Employer:	Employer phone no.:			
Cell no.:	Home no.:	For minors: Who are the legal guardians?			
Is the patient a resident of a nursing home? If so please indicate name of the home and the home's number.					

INSURANCE INFORMATION

PRIMARY INSURANCE Policy Holder:	DOB and/or SSN:	Policy No.:	Group No.:
Name of Insurance:		Address of Insurance:	
SECONDARY INSURANCE: Policy Holder:	DOB and/or SSN:	Policy No.:	Group No.:
Name of Insurance:		Address of Insurance:	

ATTORNEY INFORMATION

Attorney Name:	Attorney Address:	Attorney Phone:

WORKERS COMPENSATION

Date of Injury:	Employer at Time of Injury:	Employer's Worker's Comp. Insurance Co. Name:
Employer's Worker's Comp. Insurance Co. Address:		Claim Number:
Adjust Name:	Phone Number:	Fax Number:

I hereby authorize the physician indicated above to furnish to the above insurance company(ies) all information which said insurance company(ies) may request and I hereby assign to the doctor all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above insurance company(ies), over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. If further agree in the event of nonpayment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

Date: _____ Signature: _____