Fort Lauderdale Orthopedics and Sports Medicine
Fort Lauderdale Orthopedic Walk-In

PATIENT REGISTRATION FORM

Date_____

Patient's Name First _____ M _____ Last _____

Date of Birth _____/____/_____ Age ____ Sex ____ Language _____ SS# _____ /____ /_____

Marital Status: ☐ Married ☐ Single ☐ Divorced | Race _____ Ethnicity: ☐White ☐Black ☐Asian ☐Hispanic ☐Other

Local Address _____ City _____ State _____ Zip_____

Permanent Address _____ City _____ State _____ Zip_____

Contact Info: Home#: _____ Mobile#: _____ Email: _____

Can we share general office communications with you? ☐Yes ☐ No

Emergency Contact _____ Phone _____ Relationship _____

Primary Care Physician Name _____ Phone _____ Fax _____

Referred by Name _____

Pharmacy Name _____ Phone: _____ Fax _____

Reason for today's visit _____ Date of onset of Symptoms ____ /____ /___

Who else has treated you for these symptoms? _____

If accident, date: ____/____/____ where did it occur: ☐ Auto ☐ Work ☐ School ☐ Home ☐ Other: _____

Attorney Name _____ Phone: _____ Fax _____

Employer Name _____ Phone: _____ Fax _____

Employer Address _____

INSURANCE INFORMATION

Primary Carrier	Secondary
Policy #	Policy #
Group #	Group #
Policy Holder	Policy Holder
Policy Holder Date of Birth	Policy Holder Date of Birth
Policy Holder SS#	Policy Holder SS#

GUARANTOR/ PERSON RESPONSIBLE FOR MEDICAL TREAMENT / EXPENSES

Full Name _____ DOB _____ /_____ /_____ Relationship _____
Local Address _____ City _____ State _____ Zip_____
Contact Info: Home#: _____ Mobile#: _____ Email: _____

FINANCIAL RESPONSIBILTY

Insurance Benefits: I, the undersigned, hereby authorize Fort Lauderdale Orthopedics and Sports Medicine and/or Fort Lauderdale Orthopedic Walk-In, to release any information acquired during my examination and/or treatment to social security administration and healthcare financing administration or its intermediaries or carriers, any information needed to Medicare, MEDIGAP, or other insurance claims. I permit a copy of this authorization to be used in place of the original and I request payment of medical insurance benefits either to myself or to the party who accepts assignment. This is a lifetime authorization. I agree to pay in full for all medical services rendered by Fort Lauderdale Orthopedics and Sports Medicine and/or Fort Lauderdale Orthopedic Walk-In. If I fail to pay my charges, I agree to pay the cost of collections, including reasonable attorney fees.

CONSENT FOR TREATMENT

I, the undersigned, whose name appears below, herby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the attending physicians.

Signature: ____ **Date**: ____