ORTHOKANSAS, LLC

Patient Registration

Please PRINT and complete ALL sections below

Personal Information & Social History

Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Best Phone #:_____

Alternate Contact #:_____

SS#:_____

Date of Birth:_____/_____/_____ Age:_____

Email:_____

Occupation:_____

Employer:_____

Phone #:_____

Referred By: ☐ Physician ☐ Coach/Trainer ☐ Other

Name of Person Referred By:_____

Spouse/Significant Other Name:_____

Sex: ☐ Male ☐ Female Other:_____

Race: ☐ American Indian/Alaska Native ☐ Asian
☐ Black ☐ Native Hawaiian ☐ White
☐ More Than One Race ☐ Unknown/Other

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Unknown

Preferred Language:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children:_____ ☐ Rt or ☐ Lt Handed

Height:_____ Weight:_____

Smoke? Yes No Packs per day?_____ # of years _____

Former Smoker? Start:_____ Stop:_____

Alcohol? Yes No Frequency?_____

Recreational Drugs? Yes No Type:_____

Hobbies/Activities:_____

_____

Insurance/Billing Information

Primary Insurance:_____

Subscriber's Name :_____

Subscriber Date of Birth:____/____/_____

Insurance ID #:_____

Group #:_____

Subscriber SS#:_____-_____-_____

Relationship to Patient:_____

Secondary Insurance:_____

Subscriber's Name :_____

Subscriber Date of Birth:____/____/_____

Insurance ID #:_____

Group #:_____

Subscriber SS#:_____-_____-_____

Relationship to Patient:_____

If someone other than the patient is responsible for billing please complete the following:

Responsible Billing Party:_____ **Relationship to Patient:**_____

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone #:_____ **Email:**_____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

Assignment of Benefits & Financial Agreement

I herey give lifetime authorization for payment of insurance benefits to be made directly to the physicians of OrthoKansas, LLC for services rendered by them. I realize that my insurance policy is a contract between me and my insurance company and that I am financially responsible for all charges 60 days after treatment whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits and agree that a photocopy of this agreement shall be valid as the original.

Date:_____ Signature:_____