EMPIRE ORTHOPAEDICS

Restore Your Freedom of Movement

Billing and Registration Form

LASTNAME _____ FIRST NAME_____

DATE OF BIRTH ___/___/____ SOCIAL SECURITY #_____-____-_____ SEX (M / F) MARITAL STATUS_____

MAILING ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ FORMER NAME(S) _____

EMERGENCY CONTACT & PHONE _____

EMPLOYER INFORMATION:

COMPANY NAME _____ WORK PHONE _____ EXT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BILLING INFORMATION:

NAME OF RESPONSIBLE PARTY (if other than self) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP _____ DATE OF BIRTH ___/___/_____ PHONE NUMBER _____

INSURANCE INFORMATION/WORKERS COMP INFO:

Please give your card to the receptionist to copy

IS CONDITION RELATED TO EMPLOYMENT?_____ AUTO ACCIDENT?_____ OTHER ACCIDENT?_____

DATE OF INJURY _____ TIME OF INJURY _____

INSURANCE 1 _____ **COPAY AMOUNT** _____

SUBSCRIBER NAME _____ RELATIONSHIP_____

CERTIFICATE # _____ GROUP # _____

INSURANCE 2 _____ **COPAY AMOUNT** _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

CERTIFICATE # _____ GROUP # _____

SUBSCRIBER DATE OF BIRTH (IF DIFFERENT THAN SELF) ___/___/_____ SOCIAL SECURITY # _____-_____-_____

I authorize the release of any medical information necessary to process this claim. (REQUIRED) Signature_____ Date _____	I authorize payment of medical benefits to my physician for services provided. (REQUIRED) Signature_____ Date _____