Comprehensive Orthopaedics of the Gulf Coast

PATIENT REGISTRATION FORM

Today's Date:_____ **Patient Number:_____**

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

First Name:	**Middle Name:**	**Last Name:**	
Gender:	**Marital Status:**	**Date of Birth:**	**Social Security Number:**
Patient's Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Number:**	**Ok to call at work?**

Please indicate if it is okay to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for you to return our call if you do not have any additional questions. This should be a phone number where only you, or anyone that you are comfortable with hearing your medical information, has access to.

Phone number(s) that it is ok to leave a message on: home work cell **Initials:_____**		
Ethnicity: (Circle One) Hispanic/Latino **Not Hispanic/Latino Unknown**	**Race:**	**Preferred Language:**
Primary Care Physician:	**Office Number:**	
Preferred Pharmacy:	**Pharmacy Cross Streets:**	**Pharmacy Phone Number:**
Occupation:	**Employer:**	**How did you hear about us?**
Email:	**How may we contact you? Circle all that apply.** **MAIL EMAIL PHONE TEXT Initials:**	

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Parent/Guardian/Spouse/Domestic Partner Information

First Name:	**Last Name:**	**Date of Birth:**	
Address:	**City**	**State**	**Zip**
Gender:	**Social Security Number:**	**Phone Number(s):**	
Relationship to Patient:	**Email:**		

INSURANCE INFORMATION Primary Insurance Coverage:

Insurance Company Name:	**ID#**	**Group#**	
Address:	**City, State, Zip:**	**Phone#**	
Name of Subscriber (MUST HAVE name, SSN, DOB to bill)	**Social Security #:**	**Subscriber's Date of Birth:**	
WORK COMP AND AUTO INSURANCE ONLY	**Date of Accident and State:**	**Claim's Adjuster Name and Contact Number:**	

INSURANCE INFORMATION Secondary Insurance Coverage:

Insurance Company Name:	ID#	Group#
Address:	City, State, Zip:	Phone#

Name of Subscriber (MUST HAVE name, SSN, DOB to bill)	Social Security #:	Subscriber's Date of Birth:

Disclosure to Release Information to Families/Emergency Contacts & Physicians I authorize Dr. Jason Rocha to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick up prescriptions and/or forms, etc, on my behalf. A photo ID is required for any pick up. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. Important Note: If you may want or need any health care information or scheduling information released to any individuals, they need to be specifically listed below. This includes individuals such as: a parent or child of a patient over 18 years of age, your primary care physician, and/or any sport coaches, etc. I authorize Dr. Jason Rocha and his staff to disclose my personal health information to the following people:

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

CONSENT FORM

I, the undersigned (or authorized representative), recognizing my need for medical care, hereby agree to the following:

1. Consent for Treatment: **Initials:**_____

I consent to and authorize the performance of any treatments, examinations, medical services, administration of drugs, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by my COGC physician or his/her assistants or designees. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of any diagnostic procedures or treatments.

2. Photo Documentation: **Initials:**_____

I hereby grant authorization for the COGC staff to make a copy of my photo identification and/or take a digital picture of me to be included in my confidential record. I further consent to the photo documentation of any injury or procedure that the clinical staff feels is necessary to include in my confidential medical record.

3. Insurance Assignment and Financial Responsibility: **Initials:**_____

I understand that I am responsible for payment of the services I receive and guarantee payment for those services.

I hereby assign to COGC, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan, insurance policy, or managed care arrangement for all insurance payments relating to medical services rendered to me by COGC. I understand that my health information will be released to insurers, payors, or other responsible parties for billing purposes. I understand that I am responsible for the cost of any applicable co-payments, deductibles, and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of physicians and/or the professional services associated with an office practice. Therefore, when permitted by law, any outstanding balance will be my responsibility.

I understand that I may receive separate bills from independent physicians or other providers related to the treatment that I receive such as labs, radiology, medical supplies, etc.

4. Notice of Privacy Practices: **Initials:**_____

I understand that Comprehensive Orthopaedics of the Gulf Coast's Notice of Privacy Practices provides information about how my health information may be used and disclosed. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. I have been offered and (if requested by me) received a copy of the Notice of Privacy Practices. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

Signature of Patient (or Parent/Legal Guardian if Patient is a Minor): _____

Printed Name of Patient: _____

Date:_____ **Relationship to patient if a minor:**_____