

**UNIVERSITY ORTHOPAEDICS AND SPORTS MEDICINE -PATIENT REGISTRATION & CONSENT FORM (Please Print)**

Patient Name: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Last First Middle

Patient's SS #: \_\_\_\_\_ Marital Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ Sep \_\_\_ Spouse's Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PCP Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How did you hear about us? Check One:  Referring Physician, Name \_\_\_\_\_

Reputation  Location  Insurance Company  Physical Therapist (Company) \_\_\_\_\_  Other \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employment Status: Full Time \_\_\_ Part Time \_\_\_ Retired \_\_\_ Not Employed \_\_\_ Student: Yes \_\_\_ No \_\_\_ If Yes, Full Time \_\_\_ Part Time \_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (Home)(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Work)(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Cell)(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**FINANCIAL RESPONSIBILITY – Complete for person responsible for bills if other than patient.**

Name: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Last First Middle

SS #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION – Please present your insurance card to the receptionist.**

Primary Insurance: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Policyholder's SS#: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Additional Insurance: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Policyholder's SS#: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I hereby authorize the physicians of University Orthopaedic Consultants to treat the patient named above for medical and surgical procedures on scheduled or emergency basis at any location. I understand and agree that I and the Responsible Person signing below are responsible for payment of my bill(s). I authorize the Group to submit claim(s) to my health insurance carrier(s) and their agents, whether private or governmental, for all services rendered by the Group or other providers involved in my care, including persons not employed by the Group who are referred for my care by the Group. I assign the benefits of such insurance to the Group and authorize payment of claim(s) directly to the Group.

I authorize the Group to release any of my medical or other information (1) to my health insurance carrier(s) and their agents in order to collect any claim(s) for payment, (2) to any and all physicians or other providers involved in my care, including persons not employed by the Group who are referred for my care by the Group, (3) to any third-party under an obligation of confidentiality performing a review of the records of the Group to assure compliance with applicable legal or accreditation requirements or to assure quality compliance, and (4) to their collection agency or collection attorney for the purposes of collecting any unpaid balance of this bill. This may include the release of information concerning HIV testing, diagnosis or treatment of AIDS, AIDS related conditions, drug or alcohol abuse or related conditions, and psychiatric and psychological conditions.

I understand the information contained in this form or otherwise given by me to the Group will be used in submitting claims for payment and I certify that such information is correct. I authorize a copy of this form to be used in place of the original, and the use of "signature on file" on all claims submissions. I understand that I am responsible for notifying the Group of any pre-certifications or referrals required by my insurance carrier(s). In the event an account becomes delinquent and collection activity is required to collect payment, I agree to pay all reasonable attorney fees and collection agency costs and/or fees associated with the collection of any unpaid balance.

I understand that Group, as used in this Patient Consent Form, means UC Physicians, and any affiliate of UC Physicians, including the following: University Radiology Associates Inc., University Internal Medicine Associates Inc., University Surgical Group of Cincinnati Inc., University Family Physicians Inc., University Dermatology Consultants Inc., Ophthalmic Consultants Inc., University Neurology Inc., University Orthopedic Consultants of Cincinnati Inc., University Ear, Nose and Throat Specialist Inc., University Surgical-Dental Associates Inc., University Rehabilitation Inc., Psychiatric Professional Services Inc., Academic Pathology Associates Inc., Foundation for Obstetrics & Gynecology Inc., University Anesthesia Associates Inc., University Physicians Inc., University Anesthesia Group Inc., University Emergency Physicians, Inc.

Signature \_\_\_\_\_ Date \_\_\_\_\_