



OMAHA ORTHOPEDIC CLINIC
 & SPORTS MEDICINE, P.C.
 11704 West Center Road, Suite 200
 Omaha, NE 68144-4327

For Office Use Only OOC Acct # _____ Initials _____

PATIENT REGISTRATION FORM

Date _____ Marital Status _____ Race _____
 Last Name _____ First Name _____ MI _____
 Home Address _____
 City _____ State _____ Zip _____
 Date of Birth _____ Age _____ Social Security # _____
 Home Phone () _____ Work Phone () _____ x _____
 Cell Phone () _____ Employer's Name _____
 Email _____

Spouse/Guardian's Name _____ & Date of Birth _____
 Spouse/Guardian's Employer _____ Work # _____
 Spouse's Social Security # _____ Alt Phone # _____

Emergency Contact Name _____ Relationship _____
 Address _____ Phone # _____

Pharmacy Name _____ **Address** _____

PCP/Referring Physician _____

Insurance Information

Primary Insurance Company _____
 Name of Policy Holder _____ Policy Holder DOB _____
 Policy # _____ Group # _____
 Secondary Insurance Company _____
 Name of Policy Owner _____
 Policy # _____ Group # _____ Do
 you have a Co-Pay with your insurance plan for office visits? _____ If
 yes, what is the amount? _____ Co-Pay's are due at the time of service.

Work Comp/IME Information (if applicable):

Name of Work Comp Insurance Company _____

Address _____

City _____ State _____ Zip _____

Claim # _____ Claims Adjuster _____

Phone # () _____ ext _____ Fax # () _____

Case Manager _____ Phone # () _____

Date of Injury _____

Auto Insurance Information (if applicable):

Name of Patient's Auto Insurance Company _____

Address _____ City _____ State _____ Zip _____

Claim # _____ Date of Accident _____

Name of person handling claim _____

Assignment of Benefits

I hereby authorize Omaha Orthopedic Clinic to furnish third party payors with any information concerning the medical care, treatment and billing.

I hereby assign Omaha Orthopedic Clinic all payments for medical services rendered to me or my dependants, and I authorize direct payment of such benefits to Omaha Orthopedic Clinic and any third party payor. I understand that I am responsible for all medical fees and costs regardless of the insurance coverage and that Medicare and insurance plans require that all co-pays and deductibles be collected. To the extent there is multiple coverage by third party payors such benefits shall be coordinated and the collection of any deductibles, co-insurance or co-payments up to the full amount of the account balance shall be permitted, and I shall remain responsible for the said amount. I agree to pay a late charge at the rate of 1-1/3 percent per month on any amounts due from and after the 31st day following the invoice date until paid in full if there is no applicable insurance coverage. If a claim is pending with a third party payor, no interest shall accrue until such time as the third party payor denies all or part of the claim, in which case I agree to pay a late charge at the rate of 1-1/3 percent per month on any unpaid amounts from and after the 31st day following the date Omaha Orthopedic Clinic or I receive notice of the same, whichever is earlier. I also agree that if any dispute arises between Omaha Orthopedic Clinic and me, the laws of the State of Nebraska shall govern, and all disputes between Omaha Orthopedic Clinic and me must only be litigated in the appropriate court in Douglas County, Nebraska, and I consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

Date: _____

Signature: _____