Beacon Orthopaedics & Sports Medicine, Ltd.
PATIENT REGISTRATION

PATIENT INFORMATION:

Patient Name	Social Security Number		
Address	Date of Birth	Age	Sex Male☐ Female☐
City/State/Zip Code	Marital Status M ☐ S ☐ D ☐ W☐	Student Yes☐ No☐	
Phone ( )	If Student Name of School/College		
Emergency Contact Name	Occupation		
Phone Number ( )	Employer		
Name of Primary Care Physician	Address		
Phone Number ( )	City/State/Zip Code		
Name of Referring Physician and/or Hospital	Phone ( )		
IS THIS VISIT DUE TO A MOTOR VEHICLE ACCIDENT? YES ☐	NO ☐ DATE OF ACCIDENT		
REASON FOR TODAY'S VISIT			
Date of Injury/ Onset	Specify Site of Injury	Right ☐	Left ☐

INSURANCE INFORMATION:

Name of Primary Insurance		
Policyholder Name		Employer *(policyholder's)*
Address *(if different)*		Address
City/State/Zip Code		City/State/Zip Code
Social Security Number	Date of Birth	Phone ( )
Name of Secondary Insurance		
Policyholder Name		Employer *(Policyholder's)*
Address *(if different)*		Address
City/State/Zip Code		City/State/Zip Code
Social Security Number	Date of Birth	Phone ( )

IF PATIENT IS A MINOR:

Mother	Date of Birth	Father	Date of Birth
Home Phone ( )	Work Phone ( )	Home Phone ( )	Work Phone ( )
Employer		Employer	
Social Security Number		Social Security Number	

I authorize Beacon Orthopaedics & Sports Medicine, Ltd. To release any information acquired in the course of examination or treatment and allow a photocopy of my signature to be used for specific insurance carriers, third party payers, or others involved in processing and collection of this claim. I hereby authorize payment of benefits due me to be made directly to Beacon Orthopaedics & Sports Medicine, Ltd. I understand that I am financially responsible for all charges.

X _____ X _____

Signature Date Authorization for Treatment for a Minor Date

****IF THIS IS A WORK RELATED INJURY, PLEASE TURN OVER THIS FORM AND COMPLETE THE BACK PORTION****

Beacon Orthopaedics & Sports Medicine, Ltd.
BWC / MCO PATIENT REGISTRATION

INFORMATION REGARDING PATIENTS INJURED ON THE JOB:

BWC / MCO INFORMATION (Managed Care Organization)	
Date of Injury	Claim #
Employer at Time of Injury	Name of MCO
Employer's Address	MCO Address
City/State/Zip Code	City/State/Zip Code
Phone ( )	Phone ( )
Contact Name at Employer	Job Title at Time of Injury

First Date Off Work _____

Allowed Condition/ Description of Injury _____

_____

_____

I hereby authorize Beacon Orthopaedics & Sports Medicine, Ltd. To disclose any information regarding this incident to my employer, insurance carrier, BWC and Worker Compensation Representative and hereby release the physicians of Beacon Orthopaedics & Sports Medicine, Ltd. from any liability arising from such disclosure. I fully understand these instructions.

I hereby authorize payment of benefits due me to be made directly to Beacon Orthopaedics & Sports Medicine, Ltd. I understand that I am financially responsible for all charges.

x _____ x _____

Signature Date