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OSSL
Orthopaedic Sports Specialists of Louisiana

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Phone (985) 625-2200
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PATIENT REGISTRATION FORM

Please PRINT. ALL information must be completed.
Mark N/A for Not Applicable. Mark P/D for Patient Declined.

Patient: _____
Last Name First Name MI
*If minor, Accompanying Parent/Guardian*_____

Today's Date: _____

Race:_____
Ethnicity: _____
Languages Spoken: _____

Date of Birth: _____Age_____ Sex: Male Female

Mailing Address: _____
City: _____State: _____ Zip: _____

Birth Order: 1 2 3 4 5 6 7 8 _____
Marital Status: Single Married Separated Divorced Widow(er)

Preferred Contact Method: Mail Phone Fax Email
Hm Ph: _____
Cell/Other:_____
Email:_____
(to access e health records)

Employer:_____
Occupation:_____
Work Phone:_____

Primary Care Physician: _____
Referring Physician: _____

Does Patient Live in a Nursing Home? Yes No
Name of Nursing Home:_____

INSURANCE INFORMATION

Primary Insurance: _____
Relationship to Insured: Self Husband Wife Child Other
Member ID #: _____Group #_____

Name of Insured: _____
Insured D.O.B. _____
Insured SSN#_____

Secondary Insurance: _____
Relationship to Insured: Self Husband Wife Child Other
Member ID #: _____Group #_____

Name of Insured:_____
Insured D.O.B. _____
Insured SSN#_____

THIRD PARTY LIABILITY INFORMATION

Is this visit school, work or accident related? Yes No
Name of Liable Party: _____

Type Accident _____
Ph: _____

Name of attorney representing patient related to this service: _____
Attorney Phone:_____ Attorney's Address:_____

**EMERGENCY CONTACT **

Name: _____Relationship: _____ Phone: _____

Insurance Assignment and Release

I certify that I have insurance coverage listed above and assign directly to Orthopaedic Sports Specialists of Louisiana, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/medical group may use my health care information and may disclose such information to indicated insurance company(ies) and their agents for the purpose of coordinating care, obtaining payment for services and determining insurance benefits for related services. This consent will continue until revoked by patient/guardian.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, made either to me or on my behalf to Orthopaedic Sports Specialists of Louisiana for any services furnished to me by that provider group. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Billing and Collections

OSSL is providing services in good faith that it will be appropriately compensated in a timely manner. Patient copayments, coinsurance & deductibles are due at time of service. The patient/guarantor will be held liable for any late fees, interests, collection fees, and/or reasonable attorneys' fees for the prosecution and/or collection of the patient amount owed. It is the patient's/guarantor's responsibility to provide updated billing and insurance information on each and every visit.

I acknowledge that the information provided is complete and accurate and that I will be held responsible for any errors or omissions.

_____ _____ _____
Patient/Guarantor Signature Printed Name Date