Denali Orthopedic Surgery, P.C.
Patient Registration Packet

Patient Information

Name: _____ Birthplace: _____
First MI Last

Mailing Address:_____City:_____State:_____Zip:_____

Physical Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____ Message/Cell Phone: (_____)_____

Social Security Number: _____/_____/_____ Gender (please circle): Female Male

Date of Birth:_____/_____/_____ Marital Status (please circle): Single Married Divorced Widowed

Spouse Name:_____ Spouse Date of Birth: _____/_____/_____

Employer Information

Employer:_____ Occupation:_____ Phone:_____

Mailing Address:_____City:_____State:_____Zip:_____

Emergency Contact Information

Primary Contact:_____ Phone/Cell:(____)_____ Relationship:_____

Secondary Contact:_____ Phone/Cell:(____)_____ Relationship:_____

How Did You Hear About Us?

☐ Family or Friend
☐ Phone Book
☐ Referral: _____
☐ Other:_____

Minor Patients (Under Age 18)

The parent or guardian accompanying the minor to the office is responsible for any charges incurred and any payments due at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements for treatment have been made. In the case of multiple guardians (divorce or separation) the financial responsibility becomes that of the guardian who accompanies the patient to their appointment. If insurance coverage is under a guardian not present at the time of service, the information pertaining to that coverage (address, SSN, ID# and group number) is required to bill the insurance. **We WILL NOT bill anyone who is absent at the time of service.**

Parent or Guardian Name:_____ Relationship:_____

Address (if different than above) _____ City:_____ State:_____ Zip:_____

Home Phone (if different from above): (_____)_____ Cell Phone: (____)_____

Social Security Number: _____/_____/_____ Date of Birth:_____/_____/_____

Employer:_____ Employer Phone:(_____)_____

Other Parent or Guardian Name:_____ Relationship:_____

Address (if different than above) _____ City:_____ State:_____ Zip:_____

Home Phone (if different from above): (_____)_____ Cell Phone: (____)_____

Social Security Number: _____/_____/_____ Date of Birth:_____/_____/_____

Employer:_____ Employer Phone:(_____)_____

Insurance/Billing Information

Will this visit be covered under Workers Compensation or Motor Vehicle/Liability Insurance? ☐ YES ☐ NO
Do you have Insurance? ☐ YES ☐ NO
If YES, please complete insurance information below:

Primary Insurance Company:_____ID#_____Group#_____
Insured Name:_____SSN:_____DOB_____
Relationship to Patient:_____Employer:_____
Insurance Address:_____City:_____State:_____Zip:_____
Insurance Phone Number:_____

Secondary Insurance Company:_____ID#_____Group#_____
Insured Name:_____SSN:_____DOB_____
Relationship to Patient: _____Employer:_____
Insurance Address:_____City:_____State:_____Zip:_____
Insurance Phone Number:_____

Authorizations (**HIPAA law makes it illegal for information to be released without the Patient's written authorization.**)

I authorize Denali Orthopedic Surgery, P.C. to discuss billing/medical information with the individual below:

Name: _____ Relationship to Patient:_____

I authorize the below individual to be present in the exam room while I am being treated and care is discussed:

Name: _____ Relationship to Patient:_____

I authorize Denali Orthopedic Surgery, P.C. to release medical information to my child's school nurse at:

_____
Name of School (Minors Only)

_____ _____
Signature **Date**

If signed by someone other than the patient, please state relationship: _____

Notice of Billing / Collection Policy / Consent for Treatment / Privacy Practices

I have been provided a copy of Denali Orthopedic Surgery's financial policy which outlines their billing/collection procedures. I authorize all proceeds from insurance to be assigned to this office where applicable. I confirm that the information I have provided is true to the best of my knowledge. Additionally, I authorize treatment of the named patient contained in this registration packet.

With my consent, Denali Orthopedic Surgery, P.C. may share my health information for treatment, billing, and healthcare operations. I have been given a copy of the practice's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Denali Orthopedic Surgery, P.C. has the right to change this notice at any time. I may obtain a current copy by contacting the office, or the Privacy Officer/Practice Manager. I may revoke my consent in writing except to the extent Denali Orthopedic Surgery has already made disclosures relying upon my prior consent.

_____ _____
Signature **Date**

If signed by someone other than the patient, please state relationship: _____