Date _____

Patient Registration

OrthoTennessee Care Center

MRN # _____

Physician _____

About The Patient

Full Name _____ (Last,) _____ (First) ____ (MI) SSN# _____

Birthdate _____ Sex _____

Address _____

City State Zip

Race _____ Language _____ Ethnicity _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

VOLUNTARY

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Employer _____ Address _____

Occupation _____

Emergency Contact Name _____ Phone # _____

Your Spouse or Parent

Name: _____ Birthdate: _____

Address _____ Phone #: _____

Employer: _____ Emp. Phone #: _____

SSN (if financially responsible) _____

Insurance

Primary

Insurance Co. Name _____

Policy #: _____ Group #: _____

Cardholder Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Secondary

Insurance Co. Name _____

Policy #: _____ Group #: _____

Cardholder Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Reason For Visit

What body part are we seeing you for? _____ Right ☐ Left ☐

Date on injury or onset of pain _____

Type of accident: Auto ☐ Worker's Comp ☐ Other ☐

Referring Physician _____ Primary Physician (if different) _____

NOTICE OF FINANCIAL OR INVESTMENT RELATIONSHIP

In order to provide you with the most comprehensive quality care, you may be referred to a facility in which OrthoTennessee physicians may have an ownership interest. This document serves as notice to you of the financial investments or relationships of the physicians of OrthoTennessee. OrthoTennessee physicians have investment interests in the following: Fort Sanders West Outpatient Surgery Center, Advanced Family Surgery Center, Knoxville Orthopedic Surgery Center, OrthoTennessee Therapy, OrthoTennessee Imaging, or OrthoTennessee Orthotics. In addition, your physician may have financial relationships with orthopedic manufacturing companies which produce surgical implants and other orthopedic products that may be used in connection with your treatment.

You may request an alternative provider for your services (physical therapy, MRI, surgery centers). If you would like to seek your medical services elsewhere, please inform your physician and you will be referred to another comparable facility. We assure you that you will not be treated differently at OrthoTennessee if you request an alternative provider. If you have any questions or concerns regarding the above notice or your treatment plan, your physician will be happy to discuss those with you.

Patient/Legal Representative Signature: _____

AUTHORIZATION FOR TREATMENT AND FILING INSURANCE

I authorize consent for treatment, the release of any medical information necessary to process this claim, and authorize payment of medical benefits to OrthoTennessee for services provided. I authorize OrthoTennessee, as part of my medical evaluation and treatment, to access my electronic medication history. I understand that I am financially responsible for the charges covered by this authorization and for collection expenses on unpaid balances.

Patient/Legal Representative Signature: _____ Date _____

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, have been made aware of OrthoTennessee's Notice of Privacy Practices that is on public display in the lobby and also available on its website (www.orthotennessee.com). I understand that I may request a paper copy of the Notice of Privacy Practices at this location.

Designated Representatives: The following people may call to ask and/or receive medical information for and about me as well as sign for prescriptions that are picked up on my behalf.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ _____

Patient/Legal Representative Signature: _____ Date _____

CONSENT FOR TREATMENT OF MINOR PATIENT

Patient Name: _____ Date of Birth: _____

By signing this form I acknowledge that I am the parent/legal guardian of the above named child and I consent to OrthoTennessee providing medical care, including, but not limited to, physical exams, routine testing and other treatments.

NOTE: legal guardian must provide proof of guardianship (court order, power of attorney, etc.)

I understand that I must be present for the initial office visit or the appointment will need to be rescheduled.

I understand and consent that my child may be seen for follow up appointments/treatments related to the initial office visit with-

Patient/Legal Representative Name: _____

Relationship to Patient: _____

Signature _____ Date _____