



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

For Office Use Only  
OOA Acct # \_\_\_\_\_  
Initials \_\_\_\_\_

## PATIENT REGISTRATION FORM

Date \_\_\_\_\_ Marital Status \_\_\_\_\_  
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 \_\_\_\_\_

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 \_\_\_\_\_

### 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: \_\_\_\_\_