OSI
ORTHOPEDIC SURGEONS, INC.

Patient Registration Form

Date _____

Primary Care Physician _____ PCP Phone _____

Patient's Name _____ M.I. _____ Last _____

Patient's Address _____ City _____ State _____ Zip _____

Patient's Home Phone _____ Patient's SSN _____ Date of Birth _____

Current Age _____ Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Spouse's Name _____

(If minor) Parent's Name _____ Parent's SSN _____

Nearest Relative (not living with you) _____ Phone _____

Are you being seen today for an accident or injury* ☐ Yes ☐ No **If yes, accident info must be completed on next page*

If yes, do you have an attorney representing you? ☐ Yes ☐ No

Attorney Name: _____ Attorney Phone _____

Patient (or) Parent Occupation _____ How Long? _____

Patient (or) Parent Employer _____ Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Primary Insurance Co. _____ Effective Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Policy Number _____ Group Number _____ Co-Pay Amt. $_____

Policy Holder _____ Policy Holder's DOB _____ Policy Holder's SSN _____

Patient's Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Son ☐ Daughter

Policy Holder's Employer _____

Secondary Insurance Co. _____ Effective Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Policy Number _____ Group Number _____ Co-Pay Amt. $_____

Policy Holder _____ Policy Holder's DOB _____ Policy Holder's SSN _____

Patient's Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Son ☐ Daughter

Policy Holder's Employer _____

North Kansas City Office
located on the campus of North Kansas City Hospital
2790 Clay Edwards Drive, Suite 650
Kansas City, MO 64116-3278
816-459-7500

Blue Springs Office
located on the campus of St. Mary's Medical Center
203 NW R.D. Mize Road, Suite 250
Blue Springs, MO 64014
816-220-8727

www.kcorthopedics.com

Continued on next page

Patient Registration PAGE 2

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Patient's Name _____ Date of Birth _____

WORK INJURY INFORMATION

Are we seeing you on this date for a work injury? ☐ Yes ☐ No

If yes, has your company been informed? ☐ Yes ☐ No Date Informed _____

Name of Work Contact _____

Date Injured _____ Body Part Injured _____

In your own words, please describe what happened _____

_____

OTHER ACCIDENT INJURY INFORMATION

Where did accident/injury occur? _____

In your own words, please describe what happened _____

_____

Who is responsible – other than Health Insurance – for your charges? _____

AUTOMOBILE INJURY/ACCIDENT INFORMATION

Are we seeing you on this date for a vehicle accident/injury? ☐ Yes ☐ No

If yes, has your automobile insurance company been informed? ☐ Yes ☐ No

Name of Person Informed _____ Date Informed _____

Date of Accident/Injury _____ Body Part Injured _____

Name of Auto Insurance _____ Insurance Agent/Adjuster _____

Auto Insurance Address _____ City _____ State _____ Zip _____

Policy Number _____ Policy Holder _____

Policy Effective Date _____ Insurance Claim Number _____

I hereby authorize payment directly to Orthopedic Surgeons, Inc., of all insurance coverage for surgery and/or office charges, and I authorize them to release any information necessary to process insurance benefits on my behalf. I also authorize the release of my medical records to any insurance company with whom I have health insurance coverage.

I understand that doctor and office fees are due and payable when services are rendered. I understand that I am fully responsible for all charges and any balance due after payment by insurance, and that insurance coverage does not necessarily guarantee payment of charges. I also understand that any account balance over 120 days will be assessed a finance charge, and/or a billing charge. Further, should legal collection become necessary, I will be responsible for any fees associated with collecting any outstanding debt.

A copy of your insurance card(s) and drivers license is required.

I, the undersigned, agree to the terms set forth in this paragraph, and authorize treatment by the doctor(s) in this office.

Signature _____ Date _____

I have received a copy of the "Notice of the Privacy Practices" from Orthopedic Surgeons, Inc. Initials _____