Carolina Regional Orthopaedics

110 Patrick Ct.
Rocky Mount, NC 27804

2906 N. Main St.
Tarboro, NC 27886

ABOUT THE PATIENT

Name_____
First Middle (Name) Last

Mailing Address_____

Street Address_____

City_____State_____Zip_____

Home #_____Work #_____

Cell Phone # _____

Email Address:_____

Social Security #_____Date of Birth____/____/_____

Male____Female____ Age_____Marital Status_____

Employer_____

Employer Address_____

Occupation _____

Referred by_____Date of Injury_____

Family Doctor_____

SPOUSE OR PARENT INFORMATION

Name_____

Relationship_____Date of Birth____/____/_____

Employer_____

Occupation_____Work #_____

Social Security #_____

EMERGENCY CONTACT PERSON
(Not living in your home)

Name_____

Relationship_____Employer_____

Home # _____Work # _____

ADDITIONAL INFORMATION

Was this injury a motor vehicle accident? Yes or No

Were you injured on the job? Yes or No

Attorney's Name for this Injury_____

How were you injured?_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company _____

Address _____

ID #_____Group # _____

Insured Name _____DOB:_____

Relationship to Insured_____

Employer of the Insured _____

MEDICAL RECORDS

Please list ALL Physicians you would like for your medical information to be shared with:

Doctor's name:_____ City_____

Doctor's name:_____ City_____

Doctor's name:_____ City_____

PLEASE READ CAREFULLY AND SIGN

I request that my insurance company pay directly to Carolina Regional Orthopaedics. I agree, I am responsible for my charges whether I have insurance coverage or not. I allow Carolina Regional Orthopaedics to release any and all medical information to process my insurance claims. I also agree to allow release of my records to other medical facility/physician for further testing and/or surgery.

I authorize Carolina Regional Orthopaedics to share medical information as needed with other health care providers who are involved with my care in order to provide continuity of care to me, their patient. This includes sending copies of my medical records by mail, fax or computer to such providers.

All accounts are past due at ninety (90) days, and finance charges of 1.5% with a minimum charge of $.50 will be added per month. I authorize that my attorney pay all charges plus finance charges directly to Carolina Regional Orthopaedics, in liability cases.

In the event I need hospitalization and/or surgery, I agree that it is my responsibility to inform the doctor of my insurance company's requirements regarding pre-admission certification or second opinion and other requirements.

PATIENT SIGNATURE_____**DATE** _____

GUARDIAN SIGNATURE_____**DATE** _____