PATIENT REGISTRATION

Jerald P. Vizzone, D.O.
Orthopaedic Surgery

Today's Date: _____

PATIENT INFORMATION

PATIENT NAME (FIRST, LAST)

ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE NO.
( )

WORK PHONE NO.
( )

DATE OF BIRTH | AGE | SEX ☐M ☐F | PATIENT'S DRIVER'S LICENSE #

SOCIAL SECURITY NO.

If patient IS UNDER 18 YEARS parent must complete this section

PARENT/GUARDIAN | **SOCIAL SECURITY NO.**

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

WHO REFERRED YOU?

REFERRING PHYSICIAN

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

AUTO ACCIDENT

If injury caused in accident patient must complete this section

INSURANCE

ADDRESS

CITY | STATE | ZIP CODE

DATE OF ACCIDENT | PHONE NO. ( )

POLICY HOLDER | POLICY NO.

CLAIM NO. | ADJUSTER'S NAME

ATTORNEY

NAME

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

INSURANCE INFO. **Must be completed even if accident injury**

PRIMARY

NAME

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

POLICY NO. | GROUP NO.

POLICY HOLDER | DATE OF BIRTH | RELATIONSHIP

SECONDARY

NAME

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

POLICY NO. | GROUP NO.

POLICY HOLDER | RELATIONSHIP

EMPLOYMENT INFO. **All patients employed must complete this section**

EMPLOYER'S NAME

ADDRESS

PHONE NO.
( )

DIRECT SUPERVISOR

WORK INJURY **If injury is work related patient must complete this section**

EMPLOYER / SUPERVISOR

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

WORKMANS COMPENSATION INSURANCE COMPANY NAME

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO. ( ) | ADJUSTER'S NAME

DATE OF ACCIDENT | CASE NO.

Please Read Reverse And Sign Where Applicable *Thank You*

PLEASE COMPLETE FORM AND RETURN TO RECEPTIONIST WITH YOUR DRIVER'S LICENSE, INSURANCE CARD, AND INSURANCE FORM IF ANY.

Date: _____ Patient Name: _____

AUTHORIZATION

☐ I hereby authorize and direct my insurance carrier to pay directly to JERALD P. VIZZONE, D.O., P.A. any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I also authorize JERALD P. VIZZONE, D.O., P.A. to release to my insurance company of any medical information necessary to process this claim.

I _____ hereby authorize you, _____ as my attorney, to send to JERALD P. VIZZONE, D.O., P.A. a letter of protection concerning any litigation that may result. FURTHERMORE, I understand that this authorization gives you permission to hold any monies out of settlement of my claim to fulfill the outstanding bill at JERALD P. VIZZONE, D.O., P.A.

AUTHORIZED SIGNATURE: _____

PERMISSION FOR X-RAY EXAMINATION INVOLVING RADIATION WITHOUT PREGNANCY TESTING

☐ JERALD P. VIZZONE, D.O., P.A. has ordered the following diagnostic procedures _____ to be performed on me. I understand that this diagnostic examination involving radiation can expose an unborn baby to small but significant risks of congenital deformity as well as other undesirable effects. Because it is difficult to know whether a pregnancy is present, JERALD P. VIZZONE, D.O., P.A. advise that a laboratory test for pregnancy be performed before the diagnostic examination. I believe that I am not pregnant, and I have decided not to have pregnancy test before the diagnostic examination. I request JERALD P. VIZZONE, D.O., P.A. to perform such diagnostic examination and I consent to such examination. I understand the risks involved, have no further questions regarding the risks, and accept full responsibility for any harmful results to an unborn child or to myself, as a result of the pregnancy and the performance of such diagnostic examination.

SIGNATURE: _____ WITNESS: _____