

# SANDHILL ORTHOPAEDIC & SPORTSMEDICINE, L.L.C.

101 East Fulton Street, Garden City, Kansas 67846-5454

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## PATIENT REGISTRATION FORM

### Patient Information: (Provide Legal name)

DATE \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_

Sex \_\_\_\_\_ Race \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Employer Telephone # ( ) \_\_\_\_\_

**Accident Information:** Date \_\_\_\_\_  Work Related  Auto  Other  
Description \_\_\_\_\_

### Responsible Party (If Different From Patient)

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_

Sex \_\_\_\_\_ Race \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Employer Telephone # ( ) \_\_\_\_\_

### Emergency Contact:

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance Information:

Primary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_

### Personal/Family Physician:

Name \_\_\_\_\_ Address \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Referred by (List Name):

Athletic Trainer: \_\_\_\_\_ Physical Therapist: \_\_\_\_\_ Nurse: \_\_\_\_\_

Physician: \_\_\_\_\_ Dr's. City \_\_\_\_\_ Other \_\_\_\_\_

How did you hear about S.O.S.? (please circle one): Fiest • SWBYP • Newspaper • Family • Friend • Other \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT** I hereby consent to routine diagnostic procedures and medical treatment by this provider. I understand that no guarantee of results has been made. This consent is good for one year unless I in writing provide a statement which revokes this consent

X \_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**INSURANCE/SELF PAY PATIENTS** I assign benefits of my medical insurance contracts to Sandhill Orthopaedic & Sportsmedicine, L.L.C. and authorize payment benefits directly to S.O.S. I authorize S.O.S. to release medical information to insurance firms as required for payment of claims for medical services. **I AGREE TO PAY ALL CHARGES NOT PAID BY INSURANCE OR OTHER MEDICAL PROGRAMS WITHIN THIRTY (30) DAYS AFTER BEING BILLED.**

X \_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**MEDICARE PATIENTS** I assign payment of authorized Medicare benefits to be made on my behalf to Sandhill Orthopaedic & Sportsmedicine for any services furnished to me. I authorize S.O.S. to release medical information to the Social Security Administration or its intermediaries or carriers as required for payment of claims. I agree to pay charges not paid by Medicare within thirty (30) days after being billed

X \_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE