Rio Grande Orthopedic Center

☐ Rick W. Bassett, MD ☐ Carmelita A. Teeter, MD

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP________________________ Pharmacy Phone ( ) __________

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (Circle One) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security #	Home Phone ( ) Other Phone ( )

Other Address	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. ____________________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ______________________________

Other Family Members Seen Here ____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND ID TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ☐ Medicare ☐ Medicaid TX ☐ Aetna ☐ BCBS ☐ CHIP's

☐ MOO ☐ Student Ins. ☐ Tricare ☐ Valley Health Plans ☐ Other ______________________

❑ Workers' Comp Injury? **Date of Injury**_____________ ❑ Accident? **Date of Accident** _____________ ❑ Auto Accident?

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other ______________________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #

Patient's Relationship to Subscriber ☐Self ☐ Spouse ☐ Child ☐ Other ______________________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rio Grande Orthopedic Center or insurance company to release any information required to process my claims.

X ____

PATIENT/GUARDIAN SIGNATURE DATE