New Patient Registration Form
Dr. Paul Kuflik

Patient Information **W/C NF Legal**

Last Name: ______________________________

First Name: ______________________________

Middle Initial _______

Social Security Number: ____________________

Date of Birth: ______/______/______

Age: ________

Sex: Male Female

Marital Status: _____________

Address: ______________________Apt. #_______

City, State, and Zip: ____________________________

Home Telephone: ______________________________

Cell: ____

E-mail Address: ______________________________

Employer Name: ___________________________

Employer Address: __________________________

City, State, Zip: ____________________________

Employer Telephone: ______________________

Student/Employment Status: ________________

Occupation: _______________________________

Guarantor Information

Rel to Guarantor: ______________________

Guarantor Name: ______________________

Guarantor SSN: ______________________

Guarantor DOB: ______________________

Guarantor Address: ____

Guarantor Telephone: ______________________

Guarantor Employer's Name: ________________________________

Guarantor Employer's Address: ________________________________

Guarantor Employer's Telephone: ________________________________

Emergency Contact Information

Emergency Contact: ________________________

Relationship: ______________________________

Telephone Number: _________________________

Additional Patient Information

Condition that brings you here: ______________________________________Date of Onset: __________

If accident, where and how did it occur? ____

Were you referred by a physician? YES________ NO_____________

If yes, name of physician requesting this consultation: ____

Address of Physician: ____ Phone: ________________

New Patient Registration Form
Dr. Paul Kuflik

Additional Patient Information

Condition that brings you here: ______________________________ **Date of Onset:** __________

If accident, where and how did it occur: ____

Did a physician refer you? Yes ____________ No ____

If yes, name of physician requesting this consultation: ____________________________________

Address of referring Physician: ____

Telephone Number: ____

Permanent Insurance Signature

I request that payment of authorized Medical Benefits be made either to me or on my behalf to the Department of Orthopaedics – Faculty Practice Associates for any service furnished to me by my physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Photostat of this authorization shall be considered as effective and valid as the original.

I acknowledge that I am financially responsible for charges not covered by my insurance carrier due to the physician's non-participating/ out-of-network status with my insurance carrier and /or due to a lack of referral or prior authorization required for today's services should one not be present at the time of service. I acknowledge that I am financially responsible for any deductible, coinsurance, and/or co-payment deemed my responsibility by my insurance carrier as well as any non-covered charges.

____

Print Patient's Name

____ ____________________

Patient's (Or Guardian's) Signature **Date**