LAKESIDE ORTHOPAEDIC CENTER LLC of Manning

Patient Registration Form

Patient Name: _____
Street Address:_____
Mailing Address:_____
Home Phone: _____ **Work Phone:** _____ **Leave a Message:** _____yes _____no

Date of Birth: _____ **Social Security Number:** _____
Marital Status: _____ **Email Address:** _____
Primary Care Physician:_____ **Referring Physician:**_____

Primary Insurance: _____ **Phone Number:** _____
Address:_____ **Date of Birth**: _____
Subscriber Name: _____ **Group Number:** _____
Subscriber ID: _____ **Social Security:** _____

Secondary Insurance:_____ **Phone Number:** _____
Address:_____ **Date Of Birth:** _____
Subscriber Name:_____ **Group Number:** _____
Subscriber ID: _____ **Social Security :** _____

Employer Name:_____ **Phone Number:** _____
Address: _____

Emergency Contact Name: _____ **Phone Number:** _____
Relationship to the Patient:_____
Pharmacy Name: _____ **Pharmacy Number:** _____

How did you hear of our practice: Referral _____ Newspaper_____ Previous Patient_____
May we send a referral thank you on your behalf? _____yes_____no

We routinely pre-cert all surgical procedures with the insurance information provided by the patient. However, a pre-cert of prior authorization does not guarantee payment.

Please note that Lakeside Orthopaedic Center requires payment at time of service for the total amount not covered by insurance. As a courtesy, we will file claims on which Dr. Woodbury is participating. If you do not have insurance, payment is expected at the time of service by cash, check, Visa or Mastercard.

If your insurance plan requires a primary care physician, please provide your physician's name. We will be glad to answer any general questions regarding insurance, but please note that each company has requirements specific to its individual plan. Questions regarding your coverage should be directed toward customer service or your human resources department at your place of employment.

By signing this form, I give Dr. Woodbury, Lakeside Orthopaedic Center, LLC, and its agents to treat the patient listed above. In addition, I give authorization to file my insurance claim and assign benefits to Lakeside Orthopaedic Center, LLC. By signing, I also agree to the above information and conditions.

_____ _____
Signature Date

_____ _____
Guardian Signature Date