Southern Orthopaedic Specialists
Drs. Chad Millet, Tim Finney, Gregor Hoffman, Claude Williams, IV, Field Ogden, Andrew Todd, Michael McNulty, Ryan Charles, & Jourdan Cancienne
Erin Kernaghan, ARNP, Diane Griener, ARNP
2731 Napoleon Avenue, New Orleans, LA 70115 * 1615 Metairie Road, Metairie, LA 70005 * (504) 897-6351

Patient Registration Form

Patient Information

Name _____ _____ _____ ☐ Male ☐ Female
Last First Middle ☐ Choose not to disclose

Address _____ _____
City State Zip

Home Ph (_____) _____ Cell Ph (_____) _____ Work Ph (_____) _____

Date of Birth _____ /_____/_____ SS#: _____-_____-_____ Single Married Widowed Divorced
(Circle One)

Personal Email _____ **Primary Care Physician:** _____

Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ French ☐ Other: _____

Race: ☐ Hispanic ☐ Asian ☐ Caucasian ☐ African American ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other

Insured Party

(Please OMIT SECTION if self)

Name _____ _____ _____ _____ /_____/_____
First M.I. Last Date of Birth

Address _____ _____
City, State, Zip

Relationship _____ Social Security # _____-_____-_____

Emergency Contact

_____ (_____)_____ _____
Name Phone Relationship

INSURANCE INFORMATION

Primary Insurance

_____
Insurance Carrier

_____
Name/DOB of Insured (if different from patient)

Secondary Insurance

_____
Insurance Carrier

_____
Name/DOB of Insured (if different from patient)

Please Continue on Page 2

Authorization to Pay Benefits to Physician: I hereby authorize Southern Orthopaedic Specialists to furnish information to insurance carriers concerning my illnesses and treatment, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. **I understand that I am responsible for any amount not covered by insurance.** I understand that if co-payments, deductibles, out of pocket expenses, non-covered services and balance due after insurance payments are due at the time of service, unless prior arrangements have been made. A photocopy of this authorization and assignment may be honored as valid. This authorization is valid until revoked by me in writing.

Authorization to Release Information: I hereby authorize Southern Orthopaedic Specialists to release any medical information necessary to process any insurance claim. I hereby authorize Southern Orthopaedic Specialists to release any medical information needed to administer Title XVIII (the Medicare program) of the Social Security Act. A photocopy of this authorization may be honored as valid. This authorization is valid until revoked by me in writing.

I understand that payment for services rendered is due at the time of the visit. **If I fail to do this, I may be assessed a $15 late fee.**

X_____ Date: _____
Patient/Guardian Signature

HIPAA – Notice of Privacy Practice

The HIPAA notice is a 5-page explanation of the privacy act. This is a form explaining that Southern Orthopaedic Specialists will not release your information to anyone without your consent. **If you would like a copy of the privacy notice, please ask the receptionist.**

I _____ give Southern Orthopaedic Specialists, a division of LMG, LLC, permission to discuss my care with (please select one):

☐ NO ONE

☐ The following individual(s):

_____

_____

X_____ Date: _____
Patient/Guardian Signature