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**Cincinnati SportsMedicine  
 and Orthopaedic Center**  
*Patient Registration*

**Patient #** **Check Office Location:**  Montgomery  Tri-County  Western Hills  Mason  Northern Kentucky

**Patient Information**

Patient Name Last First M.I.		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Age	Marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep <input type="checkbox"/>	Social Security #
Have you been seen by any of our physicians before <input type="checkbox"/> yes <input type="checkbox"/> no		If so, whom DR.	When Where		Who are you seeing today DR.	
Home street address			City & State		Zip Code	
Home Phone / Include Area Code		Mobile Phone / Include Area Code		Email Address		
Employer		Address		Occupation	Business Phone / Include Area Code	
Primary Care Physician (PCP) or Referring Physician		Did your PCP refer you here? <input type="checkbox"/> yes <input type="checkbox"/> no	PCP's or Referring Physicians address / phone to be notified of your progress			

**In order to better serve you, it's important to let us know why you selected us for your orthopaedic care. Check all boxes that apply.**

Referred by MD - please list MD name: \_\_\_\_\_ address: \_\_\_\_\_

Social Network (Facebook, YouTube, etc.)  Employer / Case Manager  Friend/Relative (specify below)  School (specify below)

Media (Radio, TV, Newspaper Ad)  Health Insurance \_\_\_\_\_

Yellow Pages  Office Location  Emergency Room (specify below)  School athletic trainer (specify below)

Current/Former Patient  Reputation of our physicians \_\_\_\_\_

Who should we notify in case of an emergency	Name/Relationship	Phone #1 / Include Area Code	Phone #2 / Include Area Code
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Address

Are you a student <input type="checkbox"/> yes <input type="checkbox"/> no	School Name	Did the injury occur while playing a sport <input type="checkbox"/> yes <input type="checkbox"/> no	Which Sport	Date of injury/onset of condition / /
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Motor Vehicle Accident <input type="checkbox"/> yes <input type="checkbox"/> no	Attorney Involved <input type="checkbox"/> yes <input type="checkbox"/> no	Attorney Name, Address & Phone
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Work-Related Injury <input type="checkbox"/> yes <input type="checkbox"/> no	Date of injury / /	Last Date Worked / /	Worker's Comp Claim #	Have you notified your employer of your injury <input type="checkbox"/> yes <input type="checkbox"/> no	Employer at time of injury
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**Insurance Information: The birthday rule applies if both parents have health insurance coverage for dependents. The parent whose birthday falls first in the year is considered the dependent's primary insurance. The parent whose birthday follows is secondary.**

<b>PRIMARY INSURANCE</b>	Effective Date	<b>SECONDARY INSURANCE</b>	Effective Date
Address		Address	
Subscriber	Birthdate of Subscriber	Subscriber	Birthdate of Subscriber
SS# of subscriber	Subscriber Policy ID#	Sex of Subscriber <input type="checkbox"/> M <input type="checkbox"/> F	SS# of subscriber Subscriber Policy ID# Sex of Subscriber <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber's Employer		Subscriber's Employer	

**Bill to Responsible Party: "Responsible Party"** If you are under 18, you should fill out the information naming your parent or legal guardian. If you are over 18, you are the person responsible for your bill (not your attorney, insurance company or employer). Parent or guardian accompanying minor children are financially responsible for all charges regardless of court orders, etc. unless written authorization to bill another party is presented at the time of your visit.

Name	Address if different from above		
Relationship to patient	Marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep	Social Security #	Home Phone / Include Area Code
Place of employment and address	Occupation	Business Phone / Include Area Code	

**Insurance Authorization and Assignment:** I understand that I am responsible for all charges, even those not paid by insurance. Co-pays will be collected prior to my physician or physical therapy visit. Payment is expected at the time services are rendered unless prior arrangements have been made or my insurance company states otherwise.

Date

Signature