Siva Orthopaedic Clinic

PHONE: 605 548 6380 FAX: 605 548 1903

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ 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:		**IC Number:**	**Best Phone Number:**			
City:		State:	PostCode:			
Occupation:	Employer:	Employer phone no.:				
Who referred you to our office?	❑ Dr.	❑ Internet	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Email:						
Other phone / Cell phone:						

INSURANCE INFORMATION

(Please give your insurance card and a picture IC 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			

Subscriber's name:	IC Number:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
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.:

I the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the hospital.

I understand that I am financially responsible for all charges, whether or not paid by insurance. I also authorize the hospital to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and authorize the insurance company to release any information required to process my claims.

Patient/Guardian signature: Date: