ADAM MADSEN, D.O.
ORTHOPEDIC SURGERY

PATIENT REGISTRATION

Today's date:

PATIENT INFORMATION

Patient's last name	First Name	Middle	Sex ○ M ○ F
SSN	Birth Date		
Mailing address			
City	State	Zip	Marital Status
Home Phone	Work Phone	Cell Phone	
Pharmacy	Email		
Employer	Employer Phone		
Employer Address (street, city, state, zip)			

INSURANCE INFORMATION

Primary Insurance Name	Policyholder	Policyholders DOB	Relationship to patient
Policyholder's Employer	Insurance Phone	Policy #	Group #
Secondary Insurance Name	Policyholder	Policyholders DOB	Relationship to patient
Policyholder's Employer	Insurance Phone	Policy #	Group #

IN CASE OF EMERGENCY

Name of Person (not living at same address)	Relationship to patient	Phone #

Consent to treat: I authorize Dr. Adam Madsen to administer such anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed advisable in the diagnosis and treatment of this patient.

Financial Agreement: The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates themselves to pay the account of the clinic. Should the account be referred to a collection agency, the undersigned shall pay reasonable attorney's fees and collection fees of 33.3%.

Assignment of Benefits: I hereby authorize payment directly to Dr. Adam Madsen, insurance benefits otherwise payable to me. I understand that I am financially responsible for any balance.

Release of Information: The Clinic or its agent may disclose all or part of the patient's medical record to any person or corporation which is or may be responsible for all or part of the payment of the patient's account.

Pharmacy: I give Dr. Adam Madsen permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

The above information is true to the best of my knowledge.

_____ _____

Patient/Guardian signature Date

_____ _____

Witness Date