PATIENT REGISTRATION

Patient Name

Date of Birth

BAY STREET
ORTHOPAEDICS & SPINE

PATIENT DETAILS		
Gender ☐ Male ☐ Female	Marital Status	
SSN		
Provider	Race	
Primary Care Provider	Hand Dominance	
PHARMACY		
Name	Phone	
CONTACT DETAILS		
Address		
City, State, Zip		
County	Phone	Cell
Email		
OCCUPATION INFORMATION		
Employment Status	Occupation	
Employer Name		
Address		
City, State, Zip		Phone
GUARANTOR DETAILS		
Guarantor	Phone	
Date of Birth	Email	
Gender ☐ Male ☐ Female	Relation	
Address		
City, State, Zip		

BAY STREET
ORTHOPAEDICS & SPINE

INSURANCE DETAILS		
Primary Insurance	Subscriber Name	
Insurance Plan #	Subscriber DOB	
Group #	Subscriber Relation	
Secondary Insurance	Subscriber Name	
Insurance Plan #	Subscriber DOB	
Group #	Subscriber Relation	
Additional Insurance Information		
EMERGENCY CONTACT		
Name	Relation	Phone
By completing this, you are allowing Bay St. Orthopaedics & Spine to provide information to your emergency contact.		

WORK- OR AUTO-RELATED INJURIES ONLY			
Is your injury:	☐ Work-related	☐ Auto-related? Date of this injury:	_____
Is this claim active?	☐ Yes	☐ No	

BILLING INFORMATION MUST BE PROVIDED PRIOR TO FIRST APPOINTMENT.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:

I AUTHORIZE THE PHYSICIANS OF BAY STREET ORTHOPAEDICS & SPINE TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT; I FURTHER AUTHORIZE PAYMENT OF SURGICAL AND/OR MEDICAL BENEFITS DIRECT TO THE PHYSICIANS OF BAY STREET ORTHOPAEDICS & SPINE. I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE AFTER PAYMENT OF SUCH BENEFITS.

Signature _____ Date _____