Stony Brook Medicine

North Fork Orthopaedic and Sports Medicine
FRED M. CARTER II, MD, FAAOS, FACS
JOHN RONGO PA-C, MS

7555 MAIN ROAD, MATTITUCK, NY 11952
TEL: (631) 298-4579 • FAX: (631) 298-4852 • NORTHFORKORTHOPEDICS.COM

A LOCATION OF STONY BROOK ORTHOPAEDIC ASSOCIATES

Patient Registration

PATIENT INFORMATION

Name: (Last, First, MI)

Address:

City: | State/Province: | Zip: | Country:

Mailing Address (if different from above):

Home Phone: | Work: | Mobile:

Email: | SSN: | Birth Date: | Sex: M ☐ F ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐

Race: White ☐ Hispanic ☐ Black/African American ☐ Other Pacific Islander ☐
Other ☐ Asian ☐ Native Hawaiian ☐ American Indian ☐

Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other ☐ | Language:

Contact Preferred: Home ☐ Work ☐ Mobile ☐

Allow Call for Appointment Reminder: Yes ☐ No ☐ | Leave Message: Yes ☐ No ☐

Primary Care Physician: | Referring Physician:

EMPLOYER INFORMATION

Employer Name: | Phone Number:

Address:

City: | State/Province: | Zip: | Country:

EMERGENCY CONTACT INFORMATION

Name: | Relationship to Patient:

Phone: | Email:

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POLICY INFORMATION

Patient is Guarantor(Insurer):	Yes ☐	No ☐	(if patient is guarantor information is the same as page 1)
Guarantor Name:			Relationship to Patient:
Guarantor Address:			
City:	State:	Zip:	Country:
Guarantor Home Phone:	Work:		Mobile:
Guarantor Birth Date:	Guarantor Sex: M ☐ F ☐		Guarantor SSN:
Guarantor Employer Name:			Phone Number:
Guarantor Address:			
City:	State:	Zip:	Country:
Primary Insurance			
Policy Number:	Insurance Company Group Name:		
Effective Date:	Expiration Date:		Policy Copay:
Secondary Insurance			
Policy Number:	Insurance Company Group Name:		
Effective Date:	Expiration Date:		Policy Copay:
Tertiary Insurance			
Policy Number:	Insurance Company Group Name:		
Effective Date:	Expiration Date:		Policy Copay:

Group #____________: Patient Name:____________________ MR#:____________ Date:__________

CLINICAL PRACTICE MANAGEMENT PLAN

Patient's Name: ____

Last First Middle

RELEASE OF INFORMATION

I hereby authorize and direct Stony Brook Orthopaedic Associates, University Faculty Practice Corporations having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

X____ ____________________

Signature of Patient or Authorized Representative Date

UNIFORM ASSIGNMENT

I hereby assign, transfer and set over to Stony Brook Orthopaedic Associates, University Faculty Practice Corporations sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the cost of care and treatment rendered to myself or my dependent.

In addition, I also assign, transfer and set over to all of the other University Faculty Practice Corporations from which I may require medical care, sufficient monies and/or benefits to which I may be entitled. These other University Faculty Practice Corporations are as follows: Stony Brook Anaesthesiology, Stony Brook Dermatology, Stony Brook Family Medical Group, Stony Brook Internists, New York Spine and Brain Surgery, Neurology Associates of Stony Brook, University Associates of Obstetrics and Gynecology, Stony Brook Preventative Medicine Services, Stony Brook Ophthalmology, Stony Brook Orthopaedic Associates., Stony Brook Children's Services, Stony Brook Psychiatric Associates., Stony Brook Radiation Oncology, Stony Brook Radiology, Stony Brook Surgical Associates, and Stony Brook Urology.

X____ ____________________

Signature of Patient or Authorized Representative Date

Account Representative: ____________________________

Group #:________ Name:____________________ MR#:__________ Date:__________

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P.O. Box 417978
Boston, MA 02241-7978

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".

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I have read and understand this information. I understand that my insurance company may deny coverage and request that __Stony Brook Orthopaedics Assoc.__ perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

____________________	____________________	____________________
Signature of Patient or Legally Authorized Representative	Print Name	Date

____________________	____________________	____________________
Witness	Print Name	Date