



OrthoOne Collierville
 Drs. Dlabach & Pickering
 99 Market Center Drive
 Collierville, TN 38017
 901-861-9610 Main
 901-861-9611 Fax

OrthoOne New Albany
 Dr. Mitias
 206 Oxford Road
 New Albany, MS 38652
 662-534-2227 Main
 662-534-2330 Fax

OrthoOne Olive Branch
 Drs. Dlabach, Mitias & Pickering
 9085 E. Sandidge Center Cove,
 Suite 200
 Olive Branch, MS 38654
 662-890-2663 Main
 662-890-2681 Fax

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name _____ First _____ MI _____

Address _____ City/State/ZIP _____

Phone: Home _____ Cell Phone _____

Date of Birth _____ SS No. _____

OrthoOne Clinic MD _____ Sex: M F Marital Status S M D W Sep

Referred By: Physician Friend/Relative Emergency Room Yellow Pages Other

Referring Physician _____ Physician Phone _____

Physician Address _____ City/State/ZIP _____

Employer _____ Employer Phone _____

Employer Address _____ City/State/ZIP _____

Emergency Contact _____ Contact phone _____

Contact Address _____ City/State/ZIP _____

RESPONSIBLE PARTY

Last Name _____ First _____ MI _____

Address _____ City/State/ZIP _____

Phone: Home _____ Date of Birth _____ SS No. _____

Employer _____ Sex: M F Marital Status S M D W Sep

Employer Address _____ Employer Phone _____

City/State/ZIP _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy No. _____ Group No. _____

Policy Holder _____ SS No. _____ Date of Birth _____

Policy Holder Address _____ City/State/ZIP _____

Relation to Patient _____ Referral No. _____ Co-pay _____

Other Insurance Co. _____ Policy No. _____ Group No. _____

Policy Holder _____ SS No. _____ Date of Birth _____

Policy Holder Address _____ City/State/ZIP _____

My signature authorizes the following: 1) release of PHI (Protected Health Information) to insurance payers as needed/requested to file for payment of all services rendered; 2) payment of insurance(s) benefits to be sent directly to OrthoOne; 3) OrthoOne to request and obtain records from any source necessary in the treatment and/or diagnosis; 4) acknowledgement that OrthoOne will file insurance(s) on your behalf; however, you are financially responsible for payment to OrthoOne for all charges made for services rendered or incurred by you or your dependents not covered by your insurance payer for any reason.

Signature (Responsible Party) _____ Date _____