

Rivergate Sports Medicine and Orthopaedic Surgery  
Registration Form  
Robert P. Landsberg, M.D.

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Employed Retired Student Disabled Male or Female

Contact Email: \_\_\_\_\_ Employer/School: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

S. S. Number: \_\_\_\_\_ Name you prefer to be called: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact/Number/Relationship: \_\_\_\_\_

Pharmacy Name/Number/Location: \_\_\_\_\_

**INSURED INFORMATION**

Insurance Card Holder's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_\_ Home Address: \_\_\_\_\_

S.S. Number: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

**REASON FOR VISIT**

Reason for today's visit: \_\_\_\_\_

Auto Accident: \_\_\_\_\_ Work Injury: \_\_\_\_\_ School Injury: \_\_\_\_\_ Other Injury: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

If Accident, where and how did it occur? \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I hereby authorize and consent to medical services including, but not limited to, diagnostic procedures, radiology procedures, laboratory procedures, local anesthesia, medical or surgical treatment which are deemed necessary or advisable by any physician employed by or affiliated with Rivergate Sports Medicine and Orthopaedic Surgery under the general or special instructions of said physicians. I understand that I am financially responsible for all charges incurred regardless of insurance coverage, including any collection charges and attorney's fees incurred for past due accounts, as well as any postage required regarding notice of delinquent accounts. I further acknowledge that any insurance benefits, when received by and paid to Dr. Robert P. Landsberg, M.D., will be credited to my account in accordance with the above assignment. **Accounts not paid within 90 days will be turned over to collection.**

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**\*PLEASE PRESENT YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST\***

What is the number we should use to call you? \_\_\_\_\_

Can we call you at home? Yes \_\_\_\_\_ No \_\_\_\_\_

Can we leave a message on your home machine? Yes \_\_\_\_\_ No \_\_\_\_\_

Can we call you at work? Yes \_\_\_\_\_ No \_\_\_\_\_

Can we leave a message on your voice mail at work? Yes \_\_\_\_\_ No \_\_\_\_\_

With whom may we discuss your health information?

Spouse \_\_\_\_\_

Parents \_\_\_\_\_

Family Member \_\_\_\_\_

Other \_\_\_\_\_

Is there anyone that we should not call or talk to regarding your health information?

\_\_\_\_\_  
\_\_\_\_\_

## HIPAA AGREEMENT

I have read and understand my rights to my personal health information as outlined in the HIPAA document. (Document is available upon request.) This signed document will be filed in the patient's chart.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Must be signed by patient or legal guardian

# RIVERGATE SPORTS MEDICINE AND ORTHOPAEDIC SURGERY

## AUTHORIZATION TO OBTAIN PATIENT INFORMATION

Request is made for information concerning records of: \_\_\_\_\_

PATIENTS DATE OF BIRTH: \_\_\_\_\_

PATIENT'S SOCIAL SECURITY NUMBER: \_\_\_\_\_

The Undersigned Hereby Authorizes Rivergate Sports Medicine And Orthopaedic Surgery Or Any Of Its Employees Or Agents To Request From The Individual Or Entity Whose Name Appears At The Bottom Of This Page, Any Report, Statement, X-Ray, Analysis, Diagnosis, Chart Or Record Maintained.

ALTHOUGH THE RELEASE IS NOT LIMITED IN SCOPE PLEASE CHECK THOSE ITEMS THAT YOU WISH SENT AT THIS TIME.

\_\_\_\_ ALL RECORDS PERTINENT TO TREATMENT AND CONTINUING CARE

\_\_\_\_ RECORDS COMPILED BETWEEN THE DATES OF \_\_\_\_\_ AND \_\_\_\_\_

\_\_\_\_ EKG REPORTS

\_\_\_\_ X-RAY REPORTS / X-RAYS

\_\_\_\_ IMMUNIZATION RECORDS

\_\_\_\_ NOTES PREPARED BY DR. \_\_\_\_\_

\_\_\_\_ OTHER (PLEASE DESCRIBE)

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If The Individual Signing This Release Is One Other Than The Patient, Then The Undersigned Agrees To Indemnify Rivergate Sports Medicine And Orthopaedic Surgery Employees, Or Agents For Any Losses Or Liability Resulting From The Release Of This Information.

### THIS ITEM(S) SHOULD BE SENT TO:

Robert P. Landsberg, M.D.  
353 New Shackle Island Rd.  
Suite 110A  
Hendersonville, TN 37075

DATE: \_\_\_\_\_

Office: 615-264-4785

Fax: 615-264-4786

X \_\_\_\_\_  
(If signed by someone other than patient, relationship)