PATIENT REGISTRATION

Patient Name ____ ☐ Male ☐ Female
last first middle initial

Mailing Address ______________________________________ Home Phone ____________
street apt. #

______________________________________ Day/Cell Phone ____________ E-mail ____________
city state zip

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Widow/er
- ☐ Dependent
- ☐ Domestic Partner

Race
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Prefer Not to Disclose
- ☐ Other ____________
- ☐ Unknown

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer Not to Disclose
- ☐ Unknown

Preferred Language ____

Birthdate ____/____/____ Age ________ Social Security# ______________________

Primary Care Physician ____
last first

Referred by Dr. ______________________________________ Phone ____________
last first

Referred by Patient/Other ______________________________ Phone ____________
last first

Patient's Employer/School ______________________________ Phone ____________

Parents/Spouse/Domestic Partner Name ____________ Employer ____________ Phone ____________

Emergency Contact Name ____________ Relationship ____________ Phone ____________

PRIMARY INSURANCE

Ins. Co. Name ______________________

Subscriber Name ______________________

Birthdate ____/____/____ Relationship ____________

Group # ____________ ID # ____________

Subscriber's Employer ______________________

Does your insurance carrier require a referral? ☐ Yes ☐ No

ANY OTHER INSURANCE

Ins. Co. Name ______________________

Subscriber Name ______________________

Birthdate ____/____/____ Relationship ____________

Group # ____________ ID # ____________

Subscriber's Employer ______________________

BILLING INFORMATION

(Complete if person responsible for bill is not the patient.)

Name of Person Responsible for Bill ______________________________________
D.O.B. relationship social security #

Address (if not as above) ______________________________________
street city state zip

Home Phone ____________________ Employer ____________________

Work Phone ____________________ Address ____________________

INFORMATION ABOUT YOUR CONDITION

What part of the body are you being seen for today? ______________________ ☐ L ☐ R

Is this a result of a work or auto injury? ☐ Yes ☐ No If **yes**, please complete the following: Date of Injury ____/____/____ Claim Number: ____________

Workers Compensation Billing Address: ______________________________________
street city state zip

Claim Manager Name: ______________________________ Phone: ____________

I authorize my insurance benefits to be paid to Orthopedic Physician Associates. I understand I am financially responsible for any balance that my insurance does not pay. I authorize the doctor or insurance company to release any information required for this claim.

______________________________________ ____________
signature date