THE ORTHOPEDIC GROUP, PC
PATIENT REGISTRATION

PERSONAL INFORMATION

FIRST NAME MI LAST NAME

ADDRESS

CITY

STATE ZIP CODE HOME PHONE NUMBER
( )

WORK PHONE NUMBER CELL PHONE NUMBER
( ) ( )

E-MAIL ADDRESS

DATE OF BIRTH AGE SEX – M or F

SOCIAL SECURITY NUMBER

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

PATIENT'S EMPLOYER OCCUPATION

STATUS:
☐ FULL TIME ☐ PART TIME

BEST TIME TO REACH YOU: MAY WE CONTACT YOU AT WORK:

STUDENT STATUS:
☐ FULL TIME ☐ PART TIME

SCHOOL NAME

SPOUSE'S NAME

SPOUSE'S SOCIAL SECURITY NUMBER

SPOUSE'S EMPLOYER OCCUPATION PHONE NUMBER
( )

YOU WERE REFERRED BY:

YOUR FAMILY DOCTORS' NAME IS: PHONE NUMBER
( )

EMERGENCY CONTACT:

NAME RELATIONSHIP

HOME PHONE NUMBER WORK NUMBER
( ) ( )

PRIMARY HEALTH INSURANCE

INSURED'S NAME (EXAMPLE: SELF, SPOUSE, OR PARENT'S NAME)

NAME OF INSURANCE COMPANY

INSURED'S EMPLOYER

ID NUMBER GROUP NUMBER

COPAY AMOUNT INSURED'S BIRTHDATE

RELATIONSHIP TO PATIENT:
☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

SECONDARY HEALTH INSURANCE

INSURED'S NAME EMPLOYER

NAME OF INSURANCE COMPANY

ID NUMBER GROUP NUMBER

COPAY AMOUNT INSURED'S BIRTHDATE

RELATIONSHIP TO PATIENT:
☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

Name of parent/guardian if patient is a minor_____

PLEASE READ, SIGN, AND DATE:

I request that payment of authorized Medicare/other insurance benefits be made on my behalf to THE ORTHOPEDIC GROUP, PC for any services furnished me by physician or supplier. I authorize the release of my medical information to the Centers for Medicare & Medicaid Services and/or my insurance company and its agents; any information needed to determine these benefits/benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as co-payments and deductibles.

SIGNATURE: _____

DATE: _____