

# 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 <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
PATIENT'S EMPLOYER		OCCUPATION
STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		
BEST TIME TO REACH YOU:	MAY WE CONTACT YOU AT WORK:	
STUDENT STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		
SCHOOL NAME		
SPOUSE'S NAME		
SPOUSE'S SOCIAL SECURITY NUMBER		
SPOUSE'S EMPLOYER	OCCUPATION	PHONE NUMBER (    )

YOU WERE REFERRED BY:
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YOUR FAMILY DOCTORS' NAME IS:	PHONE NUMBER (    )
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### 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: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	

### SECONDARY HEALTH INSURANCE

INSURED'S NAME	EMPLOYER
NAME OF INSURANCE COMPANY	
ID NUMBER	GROUP NUMBER
COPAY AMOUNT	INSURED'S BIRTHDATE
RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> 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: \_\_\_\_\_