REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's **Last name:** **First:** **Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former/maiden name):	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F

Street address:	**Social Security no.:**	**Home phone no.:** ( )

P.O. box:	**City**:	**State:**	**ZIP Code:**

Occupation:	Employer:	Employer phone no.: ( )

Is this patient a minor? ❑ Yes ❑ No	IF MINOR: Father's Name: Father's occupation:	IF MINOR: Mother's Name: Mother's occupation:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Responsible Party:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance:

What type of insurance is this? ❑ Commercial ❑ Worker's Comp ❑Motor Vehicle

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Orthopedic & Sports Specialists of Louisville, P.S.C. or insurance company to release any information required to process my claims.

X _____ _____

Patient/Guardian signature *Date*