

Chart \_\_\_\_\_

## Patient Registration Form

Guar ID \_\_\_\_\_

### Patient Info

First Name \_\_\_\_\_ MI \_\_\_\_\_  
Last Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
City, St Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender  M  F  
Marital Status  S  M  D  W  
Social Security No. \_\_\_\_\_  
Nickname \_\_\_\_\_  
Emergency Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Emergency Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Employment Status \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Emp Address \_\_\_\_\_  
Emp City, St Zip \_\_\_\_\_  
Work Phone \_\_\_\_\_

How to Contact You? Circle which are ok  
Phone: Cell Home Work Email  
Can we leave a voice mail? Yes or No  
Anyone to exclude from your information?

### Primary Insurance Info

Insurance Name \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_  
Policy ID/Number \_\_\_\_\_  
Group Number \_\_\_\_\_  
Date of Birth (Policy Holder) \_\_\_\_\_  
SSN of Policy Holder \_\_\_\_\_  
Insurance Phone \_\_\_\_\_  
Ins Address \_\_\_\_\_  
Ins City, St Zip \_\_\_\_\_  
Employer of Policy Holder \_\_\_\_\_  
Referral Needed? \_\_\_\_\_ Copay \_\_\_\_\_

### Secondary Insurance Info

Secondary Ins \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_  
Policy ID/Number \_\_\_\_\_  
Group Number \_\_\_\_\_  
Date of Birth (Policy Holder) \_\_\_\_\_  
SSN of Policy Holder \_\_\_\_\_  
Insurance Phone \_\_\_\_\_  
Ins Address \_\_\_\_\_  
Ins City, St Zip \_\_\_\_\_  
Employer of Policy Holder \_\_\_\_\_  
Referral Needed? \_\_\_\_\_ Copay \_\_\_\_\_

### Responsible Party/Billing Info

Responsible Party (for Billing)  
If not patient, relationship \_\_\_\_\_  
First Name \_\_\_\_\_ MI \_\_\_\_\_  
Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, St Zip \_\_\_\_\_  
Home Phone of Resp Party \_\_\_\_\_  
DOB of Responsible Party \_\_\_\_\_  
Gender ( ) or circle M F  
Marital Status S M W D  
Social Security No. \_\_\_\_\_  
Employment Status \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Emp Address \_\_\_\_\_  
Emp City, St Zip \_\_\_\_\_  
Work Phone \_\_\_\_\_

### Industrial/BWC Claim

BWC Claim Number \_\_\_\_\_  
Date of Injury \_\_\_\_\_  
Date Last Worked \_\_\_\_\_  
Date Returned to Work \_\_\_\_\_  
Industrial Insurance (MCO) Name \_\_\_\_\_

Contact Name \_\_\_\_\_  
MCO Phone \_\_\_\_\_  
MCO Fax \_\_\_\_\_  
MCO Address \_\_\_\_\_  
MCO City, St Zip \_\_\_\_\_  
Was the Injury Reported? Y N ?  
Describe Injury \_\_\_\_\_

Occupation \_\_\_\_\_  
Employer at time of Injury \_\_\_\_\_  
Emp Address \_\_\_\_\_

Emp Phone \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Allowed Codes \_\_\_\_\_

### Accident Info

Date of Injury \_\_\_\_\_  
Type of Accident- Auto Home Work Other  
Who treated you first? \_\_\_\_\_  
Lawsuit Pending? \_\_\_\_\_

### Your Lifetime Release and Authorization

"I request that payment of authorized insurance benefits be made to OrthoWest, Ltd. for any services furnished to me by OrthoWest, Ltd. I understand that if I do not have a necessary referral from my PCP or authorization from my insurance company for these services, I will be held responsible for payment. In addition, I understand that I am responsible for any copayments, deductibles, and any coinsurance that may apply. I authorize any holder of medical information about me to release to my insurance company, and its agents, any information needed to determine these benefits or the benefits payable for related services or to facilitate the delivery of medical services. I hereby give my consent to OrthoWest, Ltd. to use and disclose my protected health information for the purposes of treatment, payment, and operations of my health care and this practice. Our Notice to Privacy Practices is available upon request."

X \_\_\_\_\_  
Signature of Responsible Party Date