PATIENT REGISTRATION FORM DOR:

PERSONAL INFORMATION

Patient Name:		**Birthdate:**	**Age:**	**Sex:**
Address:	**City:**	**State: MI**	**Zip:**	
Home Phone#		**Social Security #:**		
Cell Phone#:		**Martial Status: Married Single Widowed**		
Employer:	**Work Phone#:**			
Employer Address:				
Spouse Name:		**Spouse SSN:**	**DOB:**	
Referred By:		**Phone:**		
Family Doctor:		**Phone:**		
Emergency Contact:	**Phone#:**			
IF PATIENT IS A MINOR – PLEASE COMPLETE THIS AREA				
Parent/Guardian Name:		**Home Phone#:**		
Address:	**City:**	**State:**	**Zip:**	
ABOUT YOUR VISIT TODAY:				
Are you a previous patient? Yes No		**Is this an ongoing problem? Yes No**		
Body area to be treated:				
IF PROBLEM IS A RESULT OF AN INJURY PLEASE COMPLETE THIS AREA				
Date of Injury:		**Did injury occur at work? Yes No**		
Involving an Auto? Yes No		**Is this a liability claim? Yes No**		

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**
Subscribers DOB:	**Subscribers DOB:**

VERY IMPORTANT – READ CAREFULLY BEFORE SIGNING, BY SIGNING THIS FORM, YOU AGREE

***That you have requested and consented to the medical treatment determined appropriate by Southern Michigan Orthopaedics, and its physicians, and you permit Southern Michigan Orthopaedics physicians, physician assistants, nurses, and support personnel to provide care and services (including treatments, procedures, surgery, tests, and other care and services) to the above-named patient, you certify that you are the above-named patient or you have the authority to give such consent for the above-named patient;**

***To inform us if your insurance coverage is contingent on a second opinion or pre-admission approval;**

***That we may reasonably release any information from your medical or financial records that we deem appropriate, including information to file a claim with your insurance company and that a copy of your signature is as valid as the original;**

***To assign benefits, otherwise payable to you, to Southern Michigan Orthopaedics;**

***That you are financially responsible for amounts billed for the above-named patient; and**

***That you are responsible for the payment of all charges.**

_____ _____

Signature (patient or parent if minor) Date