PERSONS
ORTHOPAEDIC SPORTS MEDICINE
& JOINT REPLACEMENT CENTER

PATIENT REGISTRATION

Patient's Name:_____
Last *First* *MI*

Home Telephone:_____ Work Telephone:_____ Cell Telephone:_____

Address:_____

City: _____ State:_____ Zip:_____

Date of birth:_____ Age:_____ Sex: □ M □ F Marital status:_____

Race:_____ Ethnicity: ____ Hispanic or Latino___ Not Hispanic or Latino

Preferred Language:_____ EMAIL ADDRESS:_____@_____.com

Patient's SSN:_____

Emergency contact:_____ Relationship:_____

Phone number:_____

BILLING INFORMATION

Primary insurance:_____ Policyholder:_____

Policy ID #:_____ Relationship to patient:_____

Policyholder DOB:_____ Policyholder SSN:_____

Secondary insurance:_____ Policyholder:_____

Policy ID #: _____ Relationship to patient:_____

Policyholder DOB:_____ Policyholder SSN:_____

Work related: □ Yes □ No Date of injury:_____

NOTICE OF PRIVACY PRACTICES

I, _____ (Please print patient name) have been provided a copy of the Medical Practice's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____
Patient/Guardian signature Date

This is an authorization for treatment.