

Patient Registration Form

| Patient information | | | | | |
|--|------------------------|---|--|--|--------------------|
| Last Name | | First Name | | Middle Name | |
| Address | | | City | | State Zip Code |
| Social Security Number / / | | Date of Birth ____/____/____ mm dd yyyy | | Age | Sex F M |
| | | | | Marital Status S M W D | |
| Non-English Language Preference: <input type="checkbox"/> Polish <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ | | Race: <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other | | Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic/Latino | |
| Please rank from 1 to 5 your preferred method of contact. Reminders to your 1st choice? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Exclude those you would not like us to use.</i> Text to Cell? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| _ Home: _____ | | _ Work/Day: _____ | | _ E-Mail: _____ | |
| _ Cell/Alt: _____ | | _ Other: _____ | | | |
| Occupation | | Employer | | Employer Telephone () | |
| Employer Address | | | City | | State Zip Code |
| Contact person | Reason for Appointment | | What Side of Body? <input type="checkbox"/> Left <input type="checkbox"/> Right | | Date Symptom Began |
| Referring Physician | | | | Referring Physician Telephone () | |
| Address | | | City | | State Zip Code |
| Primary Care Physician (PCP) | | | | Primary Physician Telephone () | |
| Address | | | City | | State Zip Code |
| Health Insurance | | | | | |
| Primary Insurance | | | | Policy Number: Group/ID Number: | |
| Last Name | | First Name | | Middle Name | |
| Social Security Number / / | | Date of Birth ____/____/____ mm dd yyyy | | Insurance Phone Number () | |
| Employer Name | | | | Business Telephone () | |
| Employer Address | | City | State | Zip Code | Contact Person |
| Secondary Insurance | | | | Policy Number: Group/ID Number: | |
| Last Name | | First Name | | Middle Name | |
| Social Security Number / / | | Date of Birth ____/____/____ mm dd yyyy | | Insurance Phone Number () | |

| Guarantor/ Legal Guardian. Complete if Different from Patient | | | | |
|--|---|--|--------------------------------|--------------|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Other | | |
| Last Name | | First Name | | Relationship |
| Home Phone () | Guarantor Social Security / / | Guarantor Birth Date ____ / ____ / ____ mm dd yyyy | | |
| Address | | City | State | Zip Code |
| Workers Compensation Information | | | | |
| Work related injury <input type="checkbox"/> YES <input type="checkbox"/> NO | | If yes, date of accident: | | |
| Name of Worker's Compensation Carrier | | | Claim Number | |
| What Part of the body was Injured? | | | | |
| Address | | City | State | Zip Code |
| Phone Number () | | Date Last Worked: | | |
| Adjuster's Name | | | Phone Number () | |
| Accident Information | | | | |
| Motor vehicle / Personal related injury <input type="checkbox"/> YES <input type="checkbox"/> NO | | If yes, date of accident: | | |
| Motor Vehicle Compensation Carrier | | Claim Number | | |
| Address | | City | State | Zip Code |
| Phone Number () | | Date last worked: | State Where accident occurred: | |
| Attorney Information | | | | |
| Attorney's Name (if lawsuit is involved) | | | Phone Number () | |
| Address | | City | State | Zip Code |
| Emergency Contact (Note: Different from your home information) | | | | |
| Name | | | Relationship | |
| Home Telephone () | | Work Telephone () | | |
| How did you find out about Midwest Orthopaedics at Rush? | | | | |
| <input type="checkbox"/> Family / Friend / Relative | | <input type="checkbox"/> Sports Team (Specify): | | |
| <input type="checkbox"/> MOR/ RUSH Employee | | <input type="checkbox"/> Workman Comp./ Case Manager | | |
| <input type="checkbox"/> Physician/ MD / DO | | <input type="checkbox"/> Yellow Pages | | |
| <input type="checkbox"/> Other Healthcare Provider | | <input type="checkbox"/> Website | | |
| <input type="checkbox"/> Others (Specify): | | <input type="checkbox"/> Search Engine (Google, etc./Specify): | | |

PATIENT SIGNATURE

DATE

All the information provided above are complete and accurate to the best of my knowledge.

Photo ID, insurance card and co-pay are required on day of visit. If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility. All unpaid balances and or denied claims are your responsibility.