Orthopaedics East & Sports Medicine Center, Inc.
Patient Registration Form

Patient Information

First Name:_____ Middle:_____ Last:_____

Address:_____ City:_____State:_____Zip:_____

Email:_____Cell #: (____)_____-_____Home #: (____)_____-_____

Date of Birth:___/___/___ Sex:_____ Race:_____Marital Status:_____SS#:_____

Responsible Party (if different from patient)

First Name:_____ Middle:_____ Last:_____

Address:_____ City:_____State:_____Zip:_____

Email:_____Cell #: (_____)_____-_____Home #: (_____)_____-_____

Date of Birth:___/___/___ Sex:_____ Race:_____Marital Status:_____SS#:_____

Patient/Responsible Party Employer Information

Employer of Patient:_____Work Phone:(_____)_____-_____

Employer Address:_____City:_____State:_____Zip:_____

Occupation:_____

General Information
Please list any other contact names and numbers for rescheduling purposes

Contact Name: _____Ph # (____)____-_____Relationship_____

Contact Name: _____Ph # (____)____-_____Relationship_____

Clinical Information

Referring Physician:_____Phone:(_____)_____-_____

Primary Care Physician:_____Phone:(_____)_____-_____

What area of the body do you wish to be seen?_____

If an injury, was it due to an accident? _____YES _____ NO

Type of Accident: Auto_____ Work Related _____ Other _____

Date of Accident: _____/_____/_____

Please describe details of the accident and injury sustained:

_____

If not an accident, onset date of when specific problem started: _____/_____/_____

Allergies: _____ YES _____ NO

Smoking Status: Please check the box that best describes your smoking status and any applicable dates.

_____Never Smoker
_____Current Every Day Smoker Start Date _____
_____Current Some Day Smoker Start Date _____
_____Heavy Tobacco Smoker Start Date _____
_____Light Tobacco Smoker Start Date _____
_____Former Smoker Start Date _____ Stop Date _____

Have you received the following most recent shot available to you?

Flu ____YES _____NO _____N/A
Pneumonia ____YES _____NO _____N/A

Have you had x-rays or MRIs taken within the past six (6) months? _____ YES _____ NO
If yes, describe what type were taken as well, as when and where they were taken.
_____

If you recently had x-rays or other imaging tests, you must bring them to the appointment with you.

Insurance Information

If a work-related injury, skip to the workers' compensation section below. Medicare and Medicaid addresses are not required.

	Primary Insurance	Secondary Insurance
Name of Insurance		
Phone Number		
Insurance Address		
Group Number		
Policy Number		
Policy Holder Name		
Relationship to Policy Holder		
Policyholder Address		
Policyholder Date of Birth		
Policyholder SS#		
Policyholder Sex		

Workers' Compensation (Complete only if a work-related injury)

Employer:_____Address:_____

City:_____State:_____Zip:_____Phone (____)____-_____

Workers Compensation Insurance Carrier:_____

Address:_____

City: _____State:_____Zip:_____

Phone #: (_____)_____-_____Claim #:_____

Adjustor's Name: _____

Please remember to bring a copy of your insurance card(s) to your visit.