WEST MICHIGAN ORTHOPAEDICS

PATIENT REGISTRATION

1. GENERAL INFORMATION

Patient's full, legal name_____

Address_____

City/State/Zip_____

Phone (1)_____ ❑ Home ❑ Cell ❑ Work ❑ Other_____

Phone (2)_____ ❑ Home ❑ Cell ❑ Work ❑ Other_____

Email_____ Social Security Number_____

Date of birth_____ Age_____ Gender: ❑ M ❑ F Marital status:_____

Employer/school_____

Name of group medical insurance through patient's employer_____

If married, spouse's name_____ Spouse's date of birth_____

Spouse's employer_____ Spouse's SSN_____

Name of group medical insurance through spouse's employer_____

2. MEDICAL INFORMATION

Nature of problem or complaint_____

(Please indicate if left or right side is affected.)

If you are being seen for an injury, please provide the following information:

Date(s) of injury_____

Where did injury occur?_____

How did injury occur?_____

Emergency contact (not living with you)_____ Relationship_____

Address_____

City/State/Zip_____ Phone_____

Family physician/PCP_____

Address_____

City/State/Zip_____ Phone _____

How were you referred to our office?_____

Have you been seen in our office before? ❑ Y ❑ N If applicable, previous last name_____

3. INSURANCE INFORMATION

Did you purchase your insurance through the Health Insurance Marketplace (Exchange)? ❑ Y ❑ N

Name of primary insurance_____

Name of secondary or supplemental insurance_____

Is your injury related to: ❑ Work ❑ Automobile ❑ Liability ❑ Other_____ ❑ N/A

If workers compensation, automobile, liability or homeowner's insurance is involved, please complete the following:

Insurance company_____

Claim number_____ Adjustor/Insurance Contact_____

4. CERTIFICATION

I certify that the information provided above is correct to the best of my knowledge. I understand that a photocopy of this form may be disclosed to my insurance company.

Signature_____ Date_____

(Patient, Personal Representative, or Parent/Guardian if minor)