PATIENT REGISTRATION

OPA ortho™

Patient Name _____ ☐ Male ☐ Female
last first middle initial

Mailing Address _____ Home Phone _____
street apt. #

_____ Day/Cell Phone _____ E-mail _____
city state zip

Marital Status
☐ Single ☐ Married
☐ Separated ☐ Widow/er
☐ Dependent ☐ Domestic Partner

Race
☐ White/Caucasian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Prefer Not to Disclose
☐ Other _____ ☐ Unknown

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer Not to Disclose
☐ Unknown

Preferred Language _____

Birthdate ____/____/____ Age _____ Social Security# _____

Primary Care Physician _____
last first

Referred by Dr. _____ Phone _____
last first

Referred by Patient/Other _____ Phone _____
last first

Patient's Employer/School _____ Phone _____

Parents/Spouse/Domestic Partner Name _____ Employer _____ Phone _____

Emergency Contact Information _____

PRIMARY INSURANCE

Ins. Co. Name _____

Subscriber Name _____

Birthdate ____/____/____

Group # _____ ID # _____

Subscriber's Employer _____

Does your insurance carrier require a referral? ☐ Yes ☐ No

ANY OTHER INSURANCE

Ins. Co. Name _____

Subscriber Name _____

Birthdate ____/____/____

Group # _____ ID # _____

Subscriber's Employer _____

BILLING INFORMATION

(Complete if person responsible for bill is not the patient.)

Name of Person Responsible for Bill _____
relationship social security #

Address (if not as above) _____
street city state zip

Home Phone _____ Employer _____

Work Phone _____ Address _____

INFORMATION ABOUT YOUR CONDITION

What part of the body are you being seen for today? _____ ☐ L ☐ R

Is this the result of an injury? ☐ Yes ☐ No If **yes**, please complete the following: Date of Injury ____/____/____ Claim Number: _____

Workers Compensation Billing Address: _____
street city state zip

Claim Manager Name: _____ Phone: _____

I authorize my insurance benefits to be paid to Orthopedic Physician Associates. I understand I am financially responsible for any balance that my insurance does not pay. I authorize the doctor or insurance company to release any information required for this claim.

_____ _____
signature date