WEST IDAHO ORTHOPEDICS & SPORTS MEDICINE

PATIENT REGISTRATION FORM

Patient Information:

Last Name _____ First Name _____ Initial _____

Mailing Address _____ City_____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Method of Contact for Reminder Calls (Please Select Only One) □ Text □ Voice - Preferred Number? □ Home □ Cell □ Work

SS# _____ DOB_____ Sex (check one) □ M □ F Marital Status (check one) □ M □ S □ D □ W

Employer Name _____ Occupation_____

Emergency Contact _____ Emergency Contact Phone # _____

Can we contact you by e-mail? □ Yes □ No E-mail_____

Responsible Party – If the patient is a minor (under the age of 18), the parent/guardian bringing the patient in will be listed as the guarantor:

Patient's Legal Guardian _____

Father's Name (IF MINOR) _____SS#_____DOB_____

Father's Home Address _____City_____State_____Zip_____

Mother's Name (IF MINOR) _____SS#_____DOB_____

Mother's Home Address _____City_____State_____Zip_____

Injury/Symptom Information:

Date of Injury, or 1st Symptom _____ Primary Care or Referring Physician _____ Date Last Seen _____

Have you had any of the following procedures in regard to this injury? □ X-Ray □ MRI □ CT Scan □ Bone Density - Where_____

Work Related? □ Yes □ No Name of Workman's Comp Carrier / Claim # _____

Motor Vehicle Accident? □ Yes □ No Name of Auto Insurance Carrier / Claim # _____

Medical Insurance Information:

Primary Medical Insurance _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder's Social Security # _____ Relationship to Policy Holder _____

Secondary Medical Insurance_____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder's Social Security # _____ Relationship to Policy Holder _____

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:
I directly assign all medical/surgical benefits to West Idaho Orthopedics and Sports Medicine and understand that I am financially responsible for all charges, whether or not paid for by insurance. I hereby authorize West Idaho Orthopedics and Sports Medicine to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

I, the undersigned, acknowledge receipt of a copy of West Idaho Orthopedics and Sports Medicine Financial Policy and Notice of Privacy Practice. A copy will be available at our office(s).

Signature of Patient/Legal Guardian _____ Date_____

Printed Name of Patient/Legal Guardian _____ Date _____