Washington Orthopaedics and Sports Medicine, P.A.

Patient Registration

Registration *(Please Print Clearly)*

Name: First	M.I.	Last	Birth Date	Age	Marital Status ☐ M ☐ W ☐ S	Sex

Home Address	Apt. No.	City	State	Zip Code	Home Phone

Email	May we contact you by email? ☐ Y ☐ N	Occupation	Cell Phone

Social Security No.	Spouse / Parent's Name	Employer	Work Phone

Emergency Contact	Relationship	Day Phone	Evening Phone

Insurance Information **Preferred Pharmacy Information**

Primary Insurance	**Name of Pharmacy**
Subscriber's Name	Address
Subscriber's Date of Birth	Phone Number / Fax Number
Relationship to Patient	

Secondary Insurance	**Worker's Compensation Information**	
Subscriber's Name	Insurance Carrier	
Subscriber's Date of Birth	Date of Injury	Claim Number
Relationship to Patient	Insurance Carrier Address & Phone Number	

DEMOGRAPHICS ☐ **DECLINE TO ANSWER**

Language		**Race**		**Ethnicity**	**SMOKING STATUS**
☐ Arabic	☐ Japanese	☐ American Indian	☐ White	☐ Hispanic Origin	☐ Current every day smoker
☐ Chinese	☐ Portuguese	☐ Asian		☐ Non-Hispanic	☐ Current some day smoker
☐ English	☐ Russian	☐ Black		☐ Type-Unknown	☐ Smoker, current status unknown
☐ French	☐ Spanish	☐ Native Hawaiian			☐ Never smoker
☐ Hebrew	☐ Yiddish	☐ Type-Unknown			☐ Former smoker
					☐ Unknown if ever smoked

General Medical Information	Height:	Weight:	Severity of Pain 1-10 (mild-severe):
Current Problem	Date Injured / Onset	Auto Involved ? ☐ Y ☐ N State:	Referring Physician
Females Only Possible Pregnancy Now? ☐ Yes ☐ No	Xrays Taken? ☐ Y ☐ N Date:	Where?	Family Physician

Permission to share medical records with the following person(s):

Patient's Insurance Authorization and Assignment

I, _____ hereby authorize Washington Orthopaedics and Sports Medicine, P.A. to apply for benefits on my behalf for covered services rendered by them. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company. I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

➢ **Please Sign:** _____ (seal) **Date:** _____

I agree that Washington Orthopaedics and Sports Medicine may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

➢ **Please Sign:** _____ (seal) **Date:** _____

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices for Washington Orthopaedics and Sports Medicine, P.A.

➢ **Please Sign:** _____ (seal) **Date:** _____

I fully understand that I am directly and fully responsible to Washington Orthopaedics and Sports Medicine, P.A. for all medical bills which I incur.

➢ **Please Sign:** _____ (seal) **Date:** _____