Name:
DOB:
Chart:
Age:
Date:

Washington Orthopaedics and Sports Medicine, P.A. ***Patient Registration***

Registration *(Please Print Clearly)*

Name: First	M.I.	Last	Birth Date	Age	Marital Status	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

Insurance Information

Primary Insurance	
Subscriber's Name	Subscriber's Date of Birth
Relationship to Patient	

Secondary Insurance	
Subscriber's Name	Subscriber's Date or Birth
Relationship to Patient	

Preferred Pharmacy Information

Name of Pharmacy	Address
Phone Number / Fax Number	

Worker's Compensation Information

Insurance Carrier	
Date of Injury	Claim Number
Insurance Carrier Address & Phone Number	

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: ☐ Yes ☐ No Is it possible you could be pregnant?	Xrays Taken? ☐ Y ☐ N Date: Where?	Family Physician

Consent to Leave Phone Messages, Electronic Messages, and Access to Medical Records

I understand that as part of my health care and treatment, Washington Orthopaedics & Sports Medicine (WOSM) may need to reach me by phone/email. WOSM will provide a confirmation call via an automated system called Televox to remind you of your upcoming appointment.

☐ **I DO** authorize WOSM to leave a message on my voice mail/answering machine(s)/email regarding communication of my health care/treatment such as instructions for procedures, clinical and/or billing needs, and sending surveys for operational improvement purposes. (check all that apply)

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail Preferred contact number: _____

☐ **I DO NOT** authorize WOSM to leave a message on my home, cell, or work phone regarding communication of my health care/ treatment such as instructions for procedures, clinical and/or billing needs. **I understand that selecting this option may result in delayed communication of pertinent treatment information such as pre-op screenings, appointment confirmations, billing communications or clinical call backs. I understand that I will be responsible to make appointments to obtain this information.**

List below any person(s)/family member(s) whom you authorize access to your medical records and authorize us to leave a detailed message with regarding all aspects of your medical chart, health condition, medications, and financial history.

Name: _____ Contact Number: _____ Relationship: _____

Name: _____ Contact Number: _____ Relationship: _____

Patient or Legal Guardian Signature: _____

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. I 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:** _____

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 & Sports Medicine, P.A.

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

I give my consent to Washington Orthopaedics and Sports Medicine, P.A. for medical treatment and to align a plan of care.

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