REDWOOD ORTHOPAEDIC SURGERY ASSOCIATES

Patient Registration

PATIENT INFORMATION

Patient Name Last First M.I.

Street Address City State Zip Code

Mailing Address *(if different)*

SSN | Date of Birth | Sex | Marital Status: S M W D SEP

Hm Ph. | Cell Ph. | Email

Occupation

Employment Status

Employer

Emp. Address

Work Phone

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White

☐ Native Hawaiian or Other Pacific Islander ☐ Declined to State ☐ Other ☐ Hispanic Preferred Language _____

PRIMARY INSURANCE INFORMATION

Insurance Company (Primary)

Group # | Member ID

Subscriber

Date of Birth | Subscriber's Ph.

Subscriber's Employer

Employer Address

City State Zip

Ph. | Patient's Relationship to Subscriber

Start Date | Co-pay

SECONDARY INSURANCE INFORMATION *(if applicable)*

Insurance Company (Secondary)

Group # | Member ID

Subscriber

Date of Birth | Subscriber's Ph.

Subscriber's Employer

Employer Address

City State Zip

Ph. | Patient's Relationship to Subscriber

Start Date | Co-pay

EMERGENCY CONTACT

Patient's Relation to Contact | First M.I. Last

Contact is Parent/Guardian ☐ Yes ☐ No | Emergency Ph. | Cell Ph. | Work Ph.

RESPONSIBLE PARTY

PARENT or GUARDIAN

First M.I. Last

Home Ph. | Cell Ph. | Work Ph. | Email

GUARANTOR

First M.I. Last | Sex | Date of Birth

Address City State Zip

Home Ph. | Cell Ph. | Work Ph. | SSN

MEDICAL CONTACTS

Primary Care Physician

Address

City State Zip

Phone

Referring Physician

Address

City State Zip

Phone

Describe the injured body part: _____ (Right, Left or Both Sides)

Injury caused by: ☐ Work ☐ Accident ☐ Other Date of Injury/Symptom _____

If injury is work-related, do you have an open Worker's Comp claim? ☐ Yes ☐ No Claim # _____

Have you or a family member been treated by one of our doctors? ☐ Yes ☐ No Who referred you? _____

I hereby authorize Redwood Orthopeadic Surgery Associates to furnish information to insurance carriers concerning my illness/injury and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance.

X _____ Date: _____

Signature

_____

Address *(if different than patient)*