# REGISTRATION FORM

SOUTHERN INDIANA ORTHOPEDICS
*The Strength of Experience*

## PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Daytime Phone: _____ Cell Phone: _____

Sex (circle) M or F Email Address: _____ Present Height: _____ Present Weight: _____

Date of Birth: _____ / _____ / _____ Social Security Number: _____ Marital Status (circle) M S D W

Occupation: _____ Employer: _____

Referring Physician: _____ Family Physician: _____

## PERSON RESPONSIBLE FOR PATIENT (to be used if patient is a minor)

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ / _____ / _____ In Care of (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Social Security Number: _____

Relationship to Patient: _____

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**(MUST COMPLETE FOR CLAIM TO BE FILED)**

**PRIMARY INSURANCE COMPANY** Insurance Company: _____ Group #: _____ ID #: _____

Relationship to Patient: _____ ❑ Same As Patient

Policyholder Name: _____ Policyholder Birth Date: _____

Policyholder Address: _____ Employer: _____

**SECONDARY INSURANCE COMPANY** Insurance Company: _____ Group #: _____ ID #: _____

Relationship to Patient: _____ ❑ Same As Patient

Policyholder Name: _____ Policyholder Birth Date: _____

Policyholder Address: _____ Employer: _____

**INJURY / ILLNESS INFORMATION** Please check the appropriate reason below for current condition.

A. Workman compensation (injury occurred at work): _____ Yes: _____ No: _____

B. Personal injury other than at your home: _____ Yes: _____ No: _____

C. Auto accident: _____ Yes: _____ No: _____

Whether complaint is due to illness or injury, specify date symptoms first started or injury occurred.

(If date is unknown, please specify an estimated date) _____ / _____ / _____

Brief description of injury: _____

_____

Is there an attorney involved? Yes: _____ No: _____ Name of Attorney: _____

**PLEASE COMPLETE PATIENT HEALTH HISTORY ON OTHER SIDE**

## PATIENT HEALTH HISTORY

Pharmacy Preference (include location): _____

Please list any medications you are currently taking:

| Name of Medication | Dosage | How Often Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are you allergic to any medication? Yes: _____ No: _____ If yes, please list below.

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

## SURGERIES AND HOSPITALIZATIONS

List all surgeries you have had (including dates): _____

_____

_____

## CONTACTS

I authorize the release of medical information to the following persons. Information will not be released to any persons not listed.

1. _____

Name of Person | Area Code & Phone # | Relationship to You

2 . _____

Name of Person | Area Code & Phone # | Relationship to You

I understand I am responsible for charges **NOT** covered or paid by my insurance company. Should the account be placed with a collection agency, I will also be responsible for payment of collection fees, attorney fees, and court costs.

_____

Patient's Signature (except for minor child) Date

I authorize Southern Indiana Orthopedics to gather, maintain, and release any and all of my information that may be required for processing all claims for third-party payers (including but not exclusive of private insurance, Medicare, Medicaid, Medigap, etc.) I authorize payment of medical benefits be made directly to Southern Indiana Orthopedics.

_____

Patient's Signature (except for minor child) Date

*Southern Indiana Orthopedics, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.*