OrthoEl Paso

Patient Registration Form Today's Date: _____

Patient Info

Date of Birth: _____ ☐ Male ☐ Female Social Security #: _____ - _____ - _____

Full Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

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

E-mail Address: _____ Pharmacy: _____

Referring Physician: _____ Primary Physician: _____

Primary Insurance Info

Primary Insurance: Ins. Group #: _____ Ins. ID #: _____

Insurance Name: _____ Copay Amt: _____

Address: _____ City/State/Zip: _____

Subscriber Name: _____ Subscribers DOB: _____

Subscriber's SSN: _____ - _____ - _____ Employer: _____

Patient's Relation to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other _____

Secondary Insurance

Secondary Insurance: Ins. Group #: _____ Ins. ID #: _____

Insurance Name: _____ Copay Amt: _____

Address: _____ City/State/Zip: _____

Subscriber Name: _____ Subscribers DOB: _____

Subscriber's SSN: _____ - _____ - _____ Employer: _____

Patient's Relation to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other _____

Additional Info

Patient's Employment Status: ☐ Employed ☐ Student ☐ Unemployed ☐ Retired ☐ Disabled

Employer: _____ Occupation: _____

Is patient a student athlete: ☐ Yes ☐ No If Yes, what school: _____

Is this a Worker's Comp Claim: ☐ Yes ☐ No If Yes, Claim Number: _____

Emergency Contact:

Name: _____ Phone Number: _____