

**CENTRAL ORTHOPEDICS AND SPORTS MEDICINE, PC
REGISTRATION FORM**

Name: _____ DOB: _____ SSN: _____
Last First M.I.

Address: _____ Home # _____
Street City State Zip

Work #: _____ Cell #: _____ Best # to reach you? _Home/Work/Cell_ _____

E-mail address: _____ Communication preference (circle one) phone portal

Primary Language: _____ Race: _____ Ethnicity: _____

Current employer _____ Job Title: _____

Emergency contact: _____ Relationship: _____ Phone #: _____
(Alt # than your home phone, please)

If minor, names of parents: _____ How did you hear about us? _____

Were you referred: Y N If yes, who: _____ Primary MD: _____
First and last name First and last name

Work-related injury? **Circle one:** Y N Reported to a supervisor? **Circle One:** Y N Claim# _____

For office use:

W/C carrier: _____ Address: _____

W/C Phone #: _____ Claim# _____ Case mgr: _____

INSURANCE INFORMATION

Primary Ins: _____ Name of Member: _____ Member DOB: _____

Secondary Ins: _____ Name of Member: _____ Member DOB: _____

Payment Authorization

I authorize payment of medical benefits provided by my medical insurance described on a standard health form to Central Orthopedics and Sports Medicine, PC for services provided during my current visit as described on the standard health care information necessary to process this claim. I understand that I am financially responsible for the charges covered by this authorization and will be responsible for any collection fees or costs associated with collections not covered by my insurance.

Signature of Patient

Date

If a minor, a parent/guardian must sign. If signed by a legal representative, please list relationship:

Signature

Relationship

Date