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

Employer:_____ Job title:_____

Emergency Contact:_____Relationship:_____Phone #:_____
(Alt # than your home phone, please)

If minor, names of parents:_____

Pharmacy:_____Phone#:_____

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