



WOOSTER **Orthopaedic**  
**&**  
**Sports Medicine** CENTER  
 A tradition of innovative care that's close to home

**PATIENT REGISTRATION FORM**

**Patient** Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 S M W D  
 Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_ Marital Status (circle)  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Length of time at current address \_\_\_\_\_  
 Phone \_\_\_\_\_ Employer \_\_\_\_\_ Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_

**Spouse** Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Name \_\_\_\_\_ DOB \_\_\_\_\_ Contact Phone \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_ Employer Address \_\_\_\_\_

**Father (if patient is a minor)** Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Name \_\_\_\_\_ DOB \_\_\_\_\_ Contact Phone \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_ Employer Address \_\_\_\_\_

**Mother (if patient is a minor)** Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Name \_\_\_\_\_ DOB \_\_\_\_\_ Contact Phone \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_ Employer Address \_\_\_\_\_

**Insurance** (circle) **YES NO** If none, how do you intend to pay? (circle) **CASH CHECK CREDIT CARD**  
**Workers Compensation Claim** (circle) **YES NO**  
 Claim Number \_\_\_\_\_ Date of injury \_\_\_\_\_

Business Where Injury Occurred \_\_\_\_\_ Employer Phone \_\_\_\_\_ Employer Address \_\_\_\_\_  
**Are you currently Employed there?** (circle) **YES NO** If not, last date worked \_\_\_\_\_

**Emergency Contact**  
 Name of nearest relative not residing with you \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Primary Care Physician**  
 Name \_\_\_\_\_ Phone \_\_\_\_\_ Practice \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Physician requesting consultation (if different than above)**  
 Name \_\_\_\_\_ Phone \_\_\_\_\_ Practice \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I consent to treatment necessary for the care of the above named patient.  
 I authorize the release of all medical records to the referring and family physicians and to my insurance, if applicable.  
 I acknowledge full financial responsibility for services rendered by the treating physician of record. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.  
 I further authorize and request that insurance payments be made directly to the treating physician of record should they elect to receive such payment.  
 I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.  
 I swear that the information I have given above is true and current to the best of my knowledge.

Patient signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_