



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 _____