

**PATIENT REGISTRATION FORM – PLEASE PRINT**



Date of Visit
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Primary Care Physician and Phone Number:
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**PATIENT INFORMATION**

Last Name	Suffix (Jr, etc.)	First Name	M.I.	Age
Street Address		Zip Code	City	
Soc. Sec. No.	Home Phone	Work Phone	Cell Phone	D.O.B.
Patient's Employer		Work Address		Employer's Phone

**RESPONSIBLE PARTY INFORMATION**

Relationship to Patient	Name	Social Security No.	Driver's License No.
Street Address		Zip Code	City
Home Phone	Work Phone	Cell Phone	Name of Employer
Employer's Street Address		Zip Code	City

**INSURANCE INFORMATION**

PRIMARY INSURANCE			SECONDARY INSURANCE		
Name of Insurance Company			Name of Insurance Company		
Policy No.	Group No.	Effective Date	Policy No.	Group No.	Effective Date
Relationship to Patient	Name of Insured		Relationship to Patient	Name of Insured	
Date of Birth	Insured's Employer	Copay \$	Date of Birth	Insured's Employer	Copay \$

**INJURY INFORMATION**

Job Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury	Date Last Worked	Employer at Time of Injury
Workmans' Compensation Carrier		Where were you injured?	
How did your injury occur?		Employer rep. who authorized treatment	

**IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)**

Person to contact	Relationship	Phone Number
Street Address	City	State
		Zip

**AUTHORIZATION AND RELEASE**

*I hereby authorize SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C. (SOS) to release for insurance purposes any information acquired in the course of my examination or treatment. I authorize payment from my insurance company to be made directly to SOS for any treatment I receive while under their care. I will be responsible for any charges not paid by my insurance company. I understand that I am responsible for payment of my account, and I agree to pay all costs of collection and interest charges, including a reasonable attorney's fee.*

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Patient's/Responsible Party's Signature

\_\_\_\_\_  
Date