

APPALACHIAN ORTHOPAEDIC ASSOCIATES, P.C.
PATIENT REGISTRATION FORM

PHYSICIAN YOU ARE SEEING TODAY _____

1.) Last Name _____ First Name _____ Middle Initial _____ 2.) Date of Birth _____

3.) Social Security # _____ Male / Female _____ Married / Single / Divorced / Widowed _____
4.) (Circle one) _____ 5.) (Circle one) _____

6.) Street Address _____ City _____ State _____ Zip Code _____

7) Home Phone _____ Work Phone _____ Cell Phone _____

8.) Emergency Contact _____ Phone _____ Relationship to Patient _____

9.) Work Status: Employed / Retired / Student / Disabled (Circle one)
If Applicable: _____

9a.) Patient's Employer _____ Address _____ Telephone _____

10.) Who is your primary health insurance carrier? _____

10a.) Secondary insurance (if any)? _____

PLEASE COMPLETE THIS SECTION ONLY IF PATIENT IS A MINOR OR WE ARE FILING YOUR SPOUSE'S INSURANCE:

11.) Patient's Relationship to Policy Holder _____

11a.) Policy Holder's Full Name _____

11b.) Address if different from Patient: _____

11c.) Policy Holder's Social Security Number _____ Date of Birth _____

11d.) Policy Holder's Employer _____

11e.) Is this the primary policy: Yes _____ No _____

How did you hear about us: (Please specify, if other)

___ Physician ___ ER ___ Employer
___ Family / Friend ___ School
___ Joint Camp ___ Radio
___ Yellow Pages ___ Newspaper ___ Website
___ Billboard ___ Previously a Patient
___ Other _____

Today's date _____