Independence Orthopedics & Sports Medicine
REGISTRATION FORM

Pharmacy Name And Location

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.: (Required)	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

Who may we release information to? Answering machine? Yes No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No Driver License #

Please indicate primary insurance	☐ Anthem (BCBS)	☐ Medicare	☐ Health Alliance	☐ State Medicaid	☐ Humana

☐ Allied	☐ Health Span	☐ Cigna	☐ United Health Care	☐ Other

Subscriber's name:	Subscriber's S.S. no:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*