Patient Registration

Please complete all sections below.

Patient Information

First Name: ___ MI: ___ Last: ___

Preferred Name: ___ Gender: ___ DOB: ___

Social Security No.: ___ Email: ___

Race/Ethnicity (check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Hispanic or Latino ☐ Unspecified ☐ Declined to state

Preferred Language: ☐ English ☐ Other: ___

Please Check Preferred Contact(s):

Address: ___ Primary Phone: ___ ☐

City/State/ZIP: ___ Alternative Phone: ___ ☐

If unable to reach me, please: ☐ Leave a full detailed message. Work Phone: ___ ☐

☐ Leave me a message asking me to return your call. Email: Please enter above. ☐

Occupation: ___ ☐ Retired

Verbal Medical Information

☐ I authorize the release of verbal information to (list names): ___

☐ Information is NOT to be released to anyone. Relationship: ___ Phone: ___

Parent/Guardian Information - please complete if patient is a minor

Parent/Guardian: ___ Phone: ___ ☐ Bill to

Complete Address*: ___ Email: ___

*if different than patient information above.

Insurance Information

Insurance Company: ___ ☐ Primary ☐ Secondary ☐ Tertiary ☐ Other

Insurance Address: ___ City/State/ZIP: ___ Phone: ___

Subscriber Name: ___ DOB: ___

Insurance ID: ___ Group #: ___

Insurance Company: ___ ☐ Primary ☐ Secondary ☐ Tertiary ☐ Other

Insurance Address: ___ City/State/ZIP: ___ Phone: ___

Subscriber Name: ___ DOB: ___

Insurance ID: ___ Group #: ___

Provider Information

Primary Care Doctor: ___ Phone: ___ FAX: ___

Referring Doctor: ___ Phone: ___ FAX: ___

Emergency Contact Information

Name: ___ Relationship to Patient: ___

Primary Phone: ___ Secondary Phone: ___

Authorization

I hereby authorize the doctors of OrthoWashington to consult, examine, and perform necessary tests and/or studies appropriate for the diagnosis and/or treatment of the patient's condition. I authorize and request my insurance benefits to be paid directly to OrthoWashington for any care received by the patient. The doctor or insurance company may release any information required to process and pay any claims from the patient's health care at OrthoWashington. I understand that I am financially responsible for all charges incurred by the patient.

Print Name: ___ Date: ___

Signature: ___

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