

New Patient Registration

Physician scheduled to see:	Patient's Name:
Appointment Date:	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Professor
Appointment Time:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Date of Birth:	Home Phone:
Home Address:	Cell Phone:
Email Address	Work Phone:
Your Job: <input type="checkbox"/> None <input type="checkbox"/> PT <input type="checkbox"/> FT	Employer:
Job Title:	Are you working now? <input type="checkbox"/> Yes <input type="checkbox"/> No

Complete this section for each of your health insurance policies

Check here if you have no health insurance

Insurance Company	Entire Subscriber ID	Subscriber Name and Employer
Blue Cross/ Blue Shield		
Blue Choice		
Medicare		
Medicaid		
MVP		
Other Name:		

Address:

Next of Kin:	Home Phone:
Relationship:	Work Phone:
	Cell Phone:

Person to notify in case of emergency (Someone living at a different address)

Name:	Home Phone:
Relationship:	Work Phone:
	Cell Phone:

Family Physician:

Address:

Referred by:

Address:

Complete this section if your visit is for a WORK-RELATED injury

Body Part Injured:	Carrier Address:
Date of Injury:	
Employer's Insurance	Carrier Case #
Carrier:	

Complete this section if your visit is due to an AUTOMOBILE ACCIDENT

Check here if you were in a motor cycle accident

Auto Insurance Carrier:	Date of Accident:
Address:	Claim #

Please note:

- ✧ X-rays, MRIs, myelograms, and CTs should be hand carried by you to your first appointment. If you had these images taken at University Medical Imaging, Panorama Internal Medicine, Highland Hospital, or Strong Memorial Hospital, please inform us when you make your appointment. We will obtain them for you.
- ✧ In fairness to other patients who are waiting to receive scheduled appointments, please give us 48 hours notice if you will miss an appointment so that someone else can be seen.
- ✧ When required, insurance co-pays are due on the date of service.

In consideration of physician services to be provided to the above patient, I personally guarantee payment to University Orthopaedics Associates of Rochester and agree to be legally responsible for the orthopaedics bills for services rendered.

_____ Date _____
Parent Signature / Responsible Party

- ✧ **Please mail this form, completed, in the envelope provided.**