URMC Orthopaedics and Rehabilitation

UNIVERSITY of ROCHESTER MEDICAL CENTER

New Patient Registration

Patient's Name:	Physician/Mid-level scheduled to see:
☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss. ☐ Dr. ☐ Profess	Appointment Date:
☐ Single ☐ Married ☐ Widowed ☐ Divorced	Appointment Time:
Date of Birth:	Home Phone:
Home address:	Cell Phone:
Email address:	Work Phone:
Job status: ☐ FT ☐ PT ☐ None	Employer:

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

Family Physician:

Address:

Referred by:

Address:

Over, Please

Complete this section if your visit is for a WORK-RELATED INJURY	
Body Part Injured:	Carrier Address:
Date of Injury:	Cell Phone:
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 motorcycle accident	
Auto Insurance Carrier:	Date of Accident:
Address:	Claim #

Please Note:

- If you had imaging (x-rays, MRIs, CAT scan, MRI, Myelogram, or Bone Scan) through Strong, Highland, University Medical Imaging (UMI), Science Park or Borg and Ide, we can access these provider's images in our office. Please bring images obtained at other imaging providers with 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. Please call (585) 275-5321 for appointment scheduling.
- 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 Orthopaedic Associates of Rochester and agree to be legally responsible for the Orthopaedics bills for services rendered.

____________________________________ Date:__________________________

Parent Signature / Responsible Party

Please bring this form, along with questionnaire, completed, and any additional outside medical history information, x-rays etc. to your appointment.

Thank you.