

Orthopedic Associates of Southwest Florida, P.A.
Patient Registration

Patient
Last Name _____ First _____ MI _____ Sex: M F

Date of Birth _____ Age _____ Social Security #: _____ Marital Status: S M D W Child

Local
Address: _____ City _____ State _____ Zip _____

Northern
Address: _____ City _____ State _____ Zip _____

Year round resident? YES NO If not, please circle the months that you are in Florida: Northern Phone (____) _____
Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

Home Phone(____) _____ Work Phone(____) _____ Cell Phone(____) _____

Patient or Parent's Employer _____ Occupation _____

Spouse's Name _____ Spouse SS# _____ DOB _____

Child – (If Patient is a minor, please complete) Custody: Both Parents Mom only Dad only Other _____

Mother's Last Name _____ First _____ Phone _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Work Phone(____) _____

Father's Last Name _____ First _____ Phone _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Work Phone(____) _____

I give permission to the following person(s) to accompany my child to visits in my absence:

Name Relationship

Name Relationship

Emergency Contact Person – (Other than someone at the same address)

Last Name _____ First _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone(____) _____ Work Phone(____) _____

Referral Information – (Please indicate how you were referred to this office)

Name _____ Doctor Friend Attorney Insurance Co. Phone Book

Advertisement _____ Other _____

Name of your Local Family Physician _____ Phone Number(____) _____

Attorney – (If you are involved with litigation for an injury, please see our insurance specialist today)

Name _____ Phone Number(____) _____

Address _____ City _____ State _____ Zip _____

Insurance Information – (We will make copies of your insurance cards and Driver’s License)

PRIMARY INSURANCE: HMO PPO POS Indemnity Auto Workmen’s Comp Home Owners

Insurance Name _____ Policy # _____ Group # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Name of Policy Holder _____ DOB _____

Employer Name _____ Does your plan require Authorization for visits? YES NO

SECONDARY INSURANCE: HMO PPO POS Indemnity Auto Workmen’s Comp Home Owners

Insurance Name _____ Policy # _____ Group # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Name of Policy Holder _____ DOB _____

Employer Name _____ Does your plan require Authorization for visits? YES NO

Please circle one:

Employment Status: Full time Part time Unemployed Self employed Retired Active Duty

Student Status: Full time Part time Not a student

Patient’s Signature (or Parent if minor)

Date

Orthopedic Associates of Southwest Florida, P.A.

Explanation of Accident/Injury/Occurrence

Patient Name: _____

Many insurance companies require detail on your accident or injury before they will release payment on your medical claim. Please provide a summary of how the accident or injury occurred. To process your insurance claim, we need complete details.

If your visit today is not from an accident or injury, please state “not applicable” and SIGN at the bottom of this form.

Date of accident/injury: _____ **Time:** _____ **am/pm**

Claim Number: _____

Area of the body: _____ **Right/Left** _____

Were you injured on the job? YES NO **Was an automobile involved?** YES NO

Have you seen another physician for this injury? YES NO **Name** _____

Address: _____

Were X-rays taken? YES NO **When/Where** _____

Owner of the property where the accident/injury took place: _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Describe how the accident/injury occurred:(Please print legibly) _____

Patient's Signature (or Parent if minor)

Date