



**ORTHOPAEDIC SPECIALISTS
OF AUSTIN**

PATIENT REGISTRATION FORM

PATIENT INFORMATION		
Patient Name: Last	First	Initial
Street Address:		
City:	State:	Zip:
Home Phone:()	Cell Phone:()	
Work Phone:()	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient's Social Security #:	Date of Birth:	
ARE YOU HERE BECAUSE OF A WORK-RELATED INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please inform the receptionist.)		
EMPLOYMENT INFORMATION		
Employer:	Occupation:	
Employer's Address:		
City:	State:	Zip:
Employer's Phone: ()	Ext:	

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Spouse Name: Last	First	Initial
Spouse's Employer:	Spouse's Date of Birth:	
Spouse's Social Security #:	Spouse's Phone#:()	
EMERGENCY CONTACT INFORMATION		
Who should we contact during an emergency?		
Relationship?	Phone:()	Alt Phone()
How did you find us? (please circle one) Yellow Pages? Internet? Family/Friend? Insurance? Attorney? Physician?		

GUARANTOR INFORMATION (If patient is a minor):		
Parent's Full Name:	Relationship to patient:	
Street Address:		
City:	State:	Zip:
Home Phone:()	Alt Phone:()	
Parent's Date of Birth:	Parent's Social Security #:	

PRIMARY INSURANCE Must be completed. Please present your insurance card(s).		
Insurance Company Name:	Insurance Phone#:	
Policy ID:	Group #:	
Insurance Claims Address:		
City:	State:	Zip:
Policy Holder's Name (as it appears on card):		
Policy Holder's Date of Birth:	Policy Holder's Social Security #:	
Policy Holder's relationship to patient:	Policy Holder's Phone#:	
Policy Holder's Address (if different from patient's)		
City:	State:	Zip:

SECONDARY INSURANCE Must be completed. Please present your insurance card(s).		
Insurance Company Name:	Insurance Phone#:	
Policy ID:	Group #:	
Insurance Claims Address:		
City:	State:	Zip:
Policy Holder's Name (as it appears on card):		
Policy Holder's Date of Birth:	Policy Holder's Social Security #:	
Policy Holder's relationship to patient:	Policy Holder's Phone#:	
Policy Holder's Address (if different from patient's)		
City:	State:	Zip:

Please present your Photo ID and Insurance Card(s) to the receptionist