Pediatric
THE ORTHOPEDIC CENTER

Patient Registration Form

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Please complete this form in order to ensure proper billing of your services. **Please Print**. Today's Date: _____

Patient Information

Patient Last Name: _____

First Name: _____ MI: _____

Other Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Addr1: _____

Addr2: _____

City, State, Zip: _____

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email ☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home)

Driver's License # _____ State _____

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Other _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Race: (please choose one of the following):
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Asian
☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Home Phone: (_____) _____

Alt Phone: (_____) _____

Home E-Mail: _____

Cell Phone: (_____) _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone: (_____) _____

Insurance Information

(A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

SECONDARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Primary Care Phys.: _____

Address: _____

City, St., Zip: _____

Telephone #: (_____) _____

Refer. Phys. (if different): _____

Address: _____

City, St., Zip: _____

Telephone #: (_____) _____

Pharmacy Name, Address & Phone #: _____

Guarantor Information

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____

Addr1: _____

Addr2: _____

City, State, Zip: _____

Employer: _____

Address: _____

Work Phone: (_____) _____

Driver's License # _____ State _____

Patient's Relationship to Guarantor: _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Phone: (_____) _____

Cell Phone: (_____) _____

City, State, Zip: _____

Guarantor E-Mail: _____

Emerg. Cont.: _____

Home Phone: (_____) _____

Alt Phone: (_____) _____

Patient's Relationship to Emerg. Cont.: _____

Cell Phone: (_____) _____

How did you hear about our practice? ☐ Word of Mouth (Friend, Family, or Coworker) ☐ Google or Other Online Search

☐ Practice Website ☐ Online Reviews (Google, elp, Healthgrades, etc.) ☐ Social Media (Facebook, Instagram, etc.)

☐ Physician Referral / Emergency Room ☐ Insurance Provider or Health Plan Directory ☐ Ongoing Care / Previous Patient

☐ Community Event or Health Fair ☐ Digital Ad (Online Banner, Sponsored Post, etc.) ☐ Print Ad (Newspaper or Magazine)

☐ Billboard ☐ Radio or Podcast ☐ TV ☐ Other: _____