ORTHOPAEDIC ASSOCIATES OF WAUSAU / PRO PHYSICAL THERAPY & HAND CENTER
PATIENT REGISTRATION FORM

1. PATIENT INFORMATION **Today's Date**_____

Name_____ Social Security No: _____

Address_____ Date of Birth_____

City_____ State_____ ZIP Code_____ Employer _____

Home Phone_____ Mobile_____ Preferred Method of Contact: Voice ☐ Text ☐ Email ☐

Maiden/Former Name _____ Sex_____ Email Address _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated ☐ Unknown ☐

Race: White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American/Alaskan Native ☐ Unknown ☐

Ethnicity: Latino/Hispanic ☐ Not Hispanic or Latino ☐ Other ☐ Unknown ☐

Primary Care Physician_____

Referred to us by_____

Spouse or Parent Name_____ Spouse or Parent Home Phone_____

Do you make your own healthcare decisions? Yes ☐ No ☐

If no, who is your POA? _____

Relationship _____ **Telephone Number** _____

2. INSURANCE COVERAGE INFORMATION

ALL patients must answer →

Are you being seen for a work-related injury/condition? _____Y _____N

At this time, I, _____, represent and warrant that I
(Print Your Name)

(DO) or (DO NOT) have **Medicaid coverage.**

Circle One *– If unmarked, default is a representation that you do not have Medicaid currently. If you are completing this form on a system where you cannot* ***circle one****, please inform the staff immediately if you have Medicaid health insurance coverage.)*

Primary

Insurance Carrier _____

Employer_____

Insured's Name (Policyholder)_____

Relationship to Patient_____ Birth Date_____

Social Security #_____

Subscriber Identification #_____

Group #_____ Copay_____

Secondary

Insurance Carrier _____

Employer_____

Insured's Name (Policyholder)_____

Relationship to Patient_____ Birth Date_____

Social Security #_____

Subscriber Identification # _____

Group #_____ Copay_____

Tertiary

Insurance Carrier _____

Employer_____

Insured's Name (Policyholder)_____

Relationship to Patient_____ Birth Date_____

Social Security #_____

Subscriber Identification #_____

Group #_____ Copay_____

Workers Comp

Insurance Carrier _____

Employer_____

Claim # _____

Date of Injury_____

Body Part _____

3. ASSIGNMENT AND RELEASE OF INFORMATION

MEDICARE: I request that payment of authorized Medicare benefits be made to Orthopaedic Associates of Wausau and/or PRO Physical Therapy & Hand Center of Wausau. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian_____Date_____

ALL PATIENTS: I hereby authorize the offices of Orthopaedic Associates of Wausau and/or PRO Physical Therapy & Hand Center of Wausau (OAW/PRO), to release any medical information required during the course of examination and treatment to my insurance company(ies), and I permit payment to OAW/PRO from my insurance for any benefits due for their services rendered. I permit a photographic or other facsimile of this authorization to be used in place of the original. **I agree to pay those charges which may not be paid by my health insurance and are my responsibility per insurance benefits.**

Patient/Guardian_____Date_____

4. PRESCRIPTION HISTORY

I agree that OAW/PRO may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes.

Patient/Guardian_____Date_____

5. PATIENT COMMUNICAITONS

I authorize OAW/PRO to contact me at the phone number(s) and e-mail address I provided during my registration as a patient. OAW/PRO may contact me via phone call, text message, or e-mail. The messages may be automated, autodialed, prerecorded calls and/or texts to communicate appointment reminders, notifications regarding the availability of path or lab results, billing and collection information. I understand that I am not required to give the consent as a condition of receiving medical care or goods. I may revoke my consent to receiving such calls and/or messages at any time by contacting OAW/PRO in writing, by phone, or by following the automated prompts provided in those messages.

Patient/Guardian_____Date_____

6. PRIVACY

I acknowledge I have been provided or offered a copy of the Privacy Practices of Orthopaedic Associates of Wausau/PRO Physical Therapy and Hand Center (OAW/PRO). These can also be accessed on our website at oaw-ortho.com.

Patient/Guardian_____Date_____

DISCLOSURE/DISCLAIMER OF OWNERSHIP

PRO Physical Therapy & Hand Center of Wausau is a division of Orthopaedic Associates of Wausau, and is fully owned and operated as part of their comprehensive services that they deliver for their patients. As an OAW patient, there is no obligation for you to receive physical therapy and occupational therapy services at our clinic, and as always, you have the right to choose any rehab provider or location that you desire.

Orthopaedic Associates of Wausau and PRO PT complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

We accept cash, check, VISA MasterCard DISCOVER and offer CareCredit (www.carecredit.com)