Name:
DOB:
Chart:
Age:
Date:

ORTHOPAEDIC ASSOCIATES OF WAUSAU S.C.
PATIENT REGISTRATION FORM

1. PATIENT INFORMATION

Today's Date ____________

Name ____________ Social Security No: ____________

Address ____________

City ____________ State ____________ ZIP Code ____________

Home Phone ____________ Work Phone ____________ May we call you at work? ☐ Y ☐ N

Maiden/Former Name ____________ Employer ____________

Sex ____________ Age ____________ Date of Birth ____________ Marital Status ☐ S ☐ M ☐ W ☐ D

Primary Care Physician ____________ Referred to us by ____________

Spouse or Parent Name ____________ Employer ____________

Spouse or Parent Home Phone ____________ Work Phone ____________

Emergency Contact ____________ **Relationship** ____________

Phone ____________ (Work) ____________

2. INSURANCE COVERAGE INFORMATION

Primary	**Secondary**
Name of Health Insurance ____________	Name of Health Insurance ____________
Employer ____________	Employer ____________
Insured's Name (Policyholder) ____________	Insured's Name (Policyholder) ____________
Relationship to patient ____________ Birth Date ____________	Relationship to patient ____________ Birth Date ____________
Social Security NO. ______ - ______ - ______	Social Security NO. ______ - ______ - ______
Subscriber Identification No ____________	Subscriber Identification No ____________
Group No. ____________ CoPay ______	Group No. ____________ CoPay ______

3. ASSIGNMENT AND RELEASE OF INFORMATION / MEDICARE SIGNATURE ON FILE

I hereby assign Orthopaedic Associates of Wausau, S.C. to receive payment of authorization **MEDICARE** benefits on my behalf for medical/surgical services.

Signed ____________ Date ____________

I hereby **assign the benefits from my Insurance Carrier(s) to Orthopaedic Associates of Wausau, S.C.** for the medical/surgical benefits I am entitled.

I authorize the release of information to Orthopaedic Associates of Wausau, S.C. and the Health Care Financing Administration, and Organized Health Care Arrangements that OAW is part of, and its agents from any provider relating to medical care. I authorize release of medical information required to act on claims to carriers listed above. I permit a photographic or other facsimile of this authorization to be used in place of the original. **I also agree that I am responsible for all incurred charges regardless of insurance, including any charges denied because of insurance company's Usual and Customary charges.**

Signed ____________ Date ____________

4. PRESCRIPTION HISTORY

I agree that Orthopaedic Associates of Wausau, SC may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes.

Signed ____________ Date ____________