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

HIPAA_____

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

Name_____ Social Security No: _____

Address_____ Email Address_____

City_____ State_____ ZIP Code_____

Home Phone_____ Work Phone_____ May we call you at work? Yes ☐ No ☐

Maiden/Former Name_____ Employer _____

Sex_____ Age_____ Date of Birth_____ Marital Status_____

Primary Care Physician_____ Referred to us by_____

Spouse or Parent Name_____ Employer _____

Spouse or Parent Home Phone _____ Work Phone _____

Emergency Contact_____ Relationship_____

Phone_____ Work Phone_____

2. INSURANCE COVERAGE INFORMATION **Work Related Injury?** Yes ☐ No ☐

Primary	**Secondary**
Name of Health Insurance_____	Name of Health Insurance_____
Employer_____	Employer_____
Insured's Name (Policyholder)_____	Insured's Name (Policyholder)_____
Relationship to Patient_____ D.O.B._____	Relationship to Patient_____ D.O.B._____
Social Security #_____	Social Security #_____
Subscriber Identification #_____	Subscriber Identification #_____
Group #_____ Copay_____	Group #_____ Copay_____

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

I hereby assign Orthopaedic Associates of Wausau, and PRO Physical Therapy & Hand Center of Wausau to receive payment of authorization **MEDICARE** benefits on my behalf for medical, surgical services and/or therapy.

Signed_____ Date_____

I hereby **assign the benefits from my Insurance Carrier(s) to Orthopaedic Associates of Wausau, and/or PRO Physical Therapy & Hand Center of Wausau** for the medical, surgical and/or therapy benefits I am entitled.

I authorize the release of information to Orthopaedic Associates of Wausau, PRO Physical Therapy & Hand Center of Wausau, the Health Care Financing Administration, the Organized Health Care Arrangements that OAW and PRO PT is part of, and its agents for 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 agree to pay those charges which may not be paid by my health insurance and are my responsibility per insurance benefits.**

Signed_____ Date_____

4. PRESCRIPTION HISTORY

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

Signed_____ 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.