

**OrthoKansas, PA
Patient Registration**

Please PRINT and complete ALL sections below!

PATIENT: Personal Information

Sex: Male Female Marital Status: Single Married
 Divorced Widowed

NAME: _____

STREET ADDRESS: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Home Phone # _____ Cell Phone # _____

SS# _____ - _____ - _____

Date Of Birth: ____/____/____ Age: _____

Referred By: Physician Coach Other _____

Name Of Person Referred By: _____

Responsible Party's Name: _____

Relationship to Patient: _____

Responsible Party's Phone Number: (____) _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employers Name: _____

Employers Phone Number: (____) _____ - _____

Employers Address: _____

PATIENT INJURY INFORMATION

REASON FOR SEEING DOCTOR:

Date of injury: ____/____/____ How did injury occur? _____

Is your condition the result of a work injury? YES NO

Is your condition the result of an auto accident? YES NO

PRIMARY INSURANCE

PRIMARY INSURANCE: _____

Address: _____

Name of insured: _____

Insured Date of Birth: ____/____/____

Insurance ID #: _____

Insurance Group #: _____

Insured SS#: _____

SECONDARY INSURANCE

SECONDARY INSURANCE: _____

Address: _____

Name of insured: _____

Insured Date of Birth: ____/____/____

Insurance ID #: _____

Insurance Group #: _____

Insured SS#: _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number (home): (____) _____ Phone number (work): (____) _____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

Assignment of Benefits & Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to the physicians of OrthoKansas, PA, for services rendered by them. I realize that my insurance policy is a contract between me and my insurance company and that I am financially responsible for all charges 60 days after treatment whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits and agree that a photocopy of this agreement shall be valid as the original.

Date: _____

Your Signature: _____

ORTHOKANSAS, P.A.

TODAY'S DATE _____

NAME: _____ DOB: _____ AGE: _____

Height: _____ Weight: _____ Marital Status: M/S/D/W Number of Children: _____

Who is your primary care physician? _____

Other doctors you see for your health care: _____

Smoke? Y ___ N ___ If so, how many packs/day? _____ Number of years you've smoked? _____

Alcohol? Y ___ N ___ If so, how much per day? _____

ALLERGIES to MEDICATIONS: _____

LATEX ALLERGY: YES ___ NO ___

Other ALLERGIES _____

Surgeries: _____

Hospitalizations: _____

Do/did YOU have any of the following health problems?

Does/did anyone in your IMMEDIATE FAMILY have any of the following health problems?

NO	YES		NO	YES	WHOM?
		DIABETES			
		HEART DISEASE			
		HIGH/LOW BLOOD PRESSURE			
		STROKE			
		CANCER (What kind?)			
		KIDNEY PROBLEMS			
		SEIZURE			
		BLEEDING PROBLEMS			
		PNEUMONIA			
		HEPATITIS			
		AIDS/HIV			
		TUBERCULOSIS			
		ASTHMA/ COPD			
		ULCERS/GERD (acid reflux disease)			
		BLOOD CLOTS			
		MULTIPLE SCLEROSIS			
		RHEUMATOID ARTHRITIS			

Other health problems/chronic illness? Explain. _____

Do you have any handicaps or disabilities? If so, what are they? _____

CONTACT PERSON (in case of emergency) _____ PHONE: _____

DOCTOR (For Office Use Only) _____

ORTHOKANSAS, P.A.

TODAY'S DATE: _____

Name: _____ Date of Birth: _____

Phone – Home: _____ Work: _____ Cell: _____

Pharmacy of Choice: _____ Phone: _____

DATE	Prescription MEDICATION and DOSAGES:	<i>Non Prescription MEDICATION And DOSAGES</i> <i>(Includes over the counter Medicines + vitamins + herbal + Supplements)</i>