PATIENT REGISTRATION

Washington Circle Orthopaedic Associates PC

A Division of Centers for Advanced Orthopedics LLC

Date of Appointment ________________________

Name: Last		First		Middle
Address: Number	Street			Apt #
City		State		Zip Code
Home Phone:	Cell Phone:	Gender [ ]F [ ]M	Marital Status: [ ]M [ ]S [ ]W [ ]D	
Date of Birth:	Age:	Soc. Sec. #:	Height: Weight: Are you claustrophobic? [ ] No [ ] Yes	
Occupation:		Employer:		
Business Address:			Work Phone: Ext.	
Pharmacy Name and Phone Number:			Email:	

Emergency Contact: Spouse/Parent/Other:	Contact's Home Phone:
Address:	Contact's Work Phone:

Referred by:	***Primary Care Physician include address and/or fax***

Reason for Visit:	***Date of Onset:***
Check one of the following choices: [ ] Work Injury, [ ] Auto Accident, [ ] Sports Injury, [ ] Other Injury/Illness	Where (State or Country):
Brief Description of How the Injury, Illness or Deformity Occurred:	

I Will Be Paying Today By: [ ] Cash, [ ] Check, [ ] Credit Card (Visa, MasterCard, Discover)

Primary Insurance Carrier:	ID#:	Group #:
Insured's Name:	Insured's Date of Birth:	Insured's Soc. Sec. #:
Relationship to Patient:	Employer:	
Secondary Insurance Carrier::	ID#:	Group #:
Insured's Name:	Insured's Date of Birth:	Insured's Soc. Sec. #
Relationship to Patient:	Employer:	

If Worker's Compensation Date of injury or accident (dd-mm-yy)	Insurance Carrier:
Address:	Phone:
Claim #:	Adjuster's Name:

I authorize release of any medical information necessary to process claims from this office and request payment of medical benefits directly to The Centers for Advanced Orthopaedics LLC, Washington Circle Orthopedics Associates Division, Craig R. Faulks, M.D. and/or David M. Lutton, M.D. Also by my signature, I authorize medical treatment to my minor child listed above if applicable.

Signature:	***Date:***