



Patient Registration

Please complete all sections below.

Patient Information

First Name: MI: Last:
 Preferred Name: Gender: DOB:
 Social Security No.: Email:
 Race/Ethnicity (check all that apply): American Indian/Alaska Native Asian Black/African American
 Native Hawaiian or other Pacific Islander White Hispanic or Latino
 Unspecified Declined to state
 Preferred Language: English Other: Please Check Preferred Contact(s):
 Address: Primary Phone:
 City/State/ZIP: Alternative Phone:
 If unable to reach me, please: Leave a full detailed message. Work Phone:
 Leave me a message asking me to return your call. Email: Please enter above.
 Occupation: Retired

Verbal Medical Information

I authorize the release of verbal information to (list names):
 Information is NOT to be released to anyone. Relationship: Phone:

Parent/Guardian Information - please complete if patient is a minor

Parent/Guardian: Phone: Bill to
 Complete Address*: Email:

*if different than patient information above.

Insurance Information

Insurance Company: Primary Secondary Tertiary Other
 Insurance Address: City/State/ZIP: Phone:
 Subscriber Name: DOB: Insurance ID: Group #:
 Insurance Company: Primary Secondary Tertiary Other
 Insurance Address: City/State/ZIP: Phone:
 Subscriber Name: DOB: Insurance ID: Group #:

Provider Information

Primary Care: Phone: FAX:
 Referral Provider: Phone: FAX:

Emergency Contact Information

Name: Relationship to Patient:
 Primary Phone: Secondary Phone:

Authorization

I hereby authorize the doctors of OrthoWashington to consult, examine, and perform necessary tests and/or studies appropriate for the diagnosis and/or treatment of the patient's condition. I authorize and request my insurance benefits to be paid directly to OrthoWashington for any care received by the patient. The doctor or insurance company may release any information required to process and pay any claims from the patient's health care at OrthoWashington. I understand that I am financially responsible for all charges incurred by the patient.

Print Name: Date:
 Signature: