



ORTHOPAEDIC SURGERY SPORTS MEDICINE & REHABILITATION

Wright State Physicians

Emergency Contact Closest relative not living with patient

Contact's Phone #: - -

Doctor to be seen this initial visit:

Referring Physician:

PATIENT REGISTRATION FORM

PT NAME			
Address			
City/State		Hm Ph	- -
Zip Code		Wrk Ph	- -
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	Cell Ph	- -
Birthdate	/ /	SSN	
E-mail			

Marital Status: Single Married Divorced Other

BILLING INFORMATION GUARANTOR

NAME			
Address			
City		State	
ZIP Code		Phone (Daytime)	- -
Birthdate	/ /	SSN	

PRIMARY INSURANCE This insurance company will get billed first.

Company			
Address			
City		State	
Group #		Effective Date	/ /
Policy #		Phone	- -

Policy Holder Name	
Soc. Sec. Number	
Birthdate	/ /
Sex	M <input type="checkbox"/> F <input type="checkbox"/>
Employer	
Relation of Patient to the insured	
Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	
Other <input type="checkbox"/> Explain	

Always send a copy of the insurance card!

SECONDARY INSURANCE This insurance company will get billed after the first has paid.

Company			
Address			
City		State	
Group #		Effective Date	/ /
Policy #		Phone	- -

Policy Holder Name	
Soc. Sec. Number	
Birthdate	/ /
Sex	M <input type="checkbox"/> F <input type="checkbox"/>
Employer	
Relation of Patient to the insured	
Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	
Other <input type="checkbox"/> Explain	

Always send a copy of the insurance card!

WORKER'S COMPENSATION INSURANCE

MCO	
Claim #	
Date of injury	

Employer			
Address			
City		State	
Phone	- -	Zip	

CONSENT TO TREAT AND AUTHORIZATION FOR RELEASE OF BILLING INFORMATION
Please read completely and sign. Services may be withheld if not signed.

I recognize the need for health care and consent to services as ordered by the physician(s). I hereby authorize the release of any medical information necessary from Wright State Physicians (WSP) for insurance claim submission and/or payment for services.

I authorize payment of medical benefits to WSP for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

SIGNATURE OF PATIENT (Parent or Guardian if Minor) Date Signed