EVANGELISTA ORTHOPEDIC CLINIC

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PATIENT REGISTRATION

Name : Last, First, MI _____

Home Address _____

City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____

Work Phone _____ Social Security _____

Occupation _____ Employer _____

Primary Care Doctor _____ PCP Phone #: _____

Referred by _____ If Dr. referred, Phone #: _____

Date of Birth____ / ____ / _____ Sex □ M □ F Marital Status □ S □ M □ D □ W

Email _____ OK to leave message at home? □ Yes □ No

Emergency Contact _____Relation _____Phone _____

Race _____Ethnicity _____Primary Language _____

Pharmacy _____Cross streets _____Phone _____

Do you authorize EO clinic to share medication history with the pharmacy listed above? □ Yes □ No

Do you have an Advanced Directive? □ Yes □ No

Primary Insurance Company _____

Policy Holder _____ Date of Birth _____ / _____ / _____

ID/Policy # _____ Group # _____Co-Pay_____

Secondary Insurance Company _____

Policy Holder _____ Date of Birth _____ / _____ / _____

ID/Policy # _____ Group # _____Co-Pay_____

Work Related? □ Yes □ No **Attorney Involved** □ Yes □ No **Auto Accident**? □ Yes □ No

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Evangelista Orthopedic Clinic for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim**. I understand that I am responsible for all charges not covered by my insurance**. I authorize the release of any medical or other information necessary to process my medical claims. In addition, I authorize the release of medical information to my primary care or referring physician(s) in regard to my management.

Signature _____ Date _____