

# Jewett Orthopaedic Clinic, LLC

## Patient Registration Information

PATIENT INFORMATION										
First Name			M.I.	Last Name				Date Of Birth		Age
Street Address			Additional Address		City			State	Zip code	
Social Security Number			E-mail			Preferred Phone Number		Secondary Phone Number		
Gender	Marital Status		Race	Ethnicity			Preferred Language			
CURRENT EMPLOYER										
Employer							Phone			
Street Address			City			State		Zip code		
GUARANTOR INFORMATION										
First Name			Last Name				Date Of Birth		Gender	
Street Address			Additional Address		City			State	Zip code	
SSN			Employer Information							
EMERGENCY CONTACT										
Name							Phone			
PRIMARY INSURANCE INFORMATION										
Insurance Name			Address		City			State	Zip code	
ID/Certificate Number				Group ID/Number						
Policy Holder (Subscriber) Name					Relation To Patient		Date Of Birth		Gender	
SECONDARY INSURANCE INFORMATION										
Insurance Name			Address		City			State	Zip code	
ID/Certificate Number				Group ID/Number						
Policy Holder (Subscriber) Name					Relation To Patient		Date Of Birth		Gender	
ACCIDENT INSURANCE INFORMATION										
Employment <input type="checkbox"/> Yes <input type="checkbox"/> No			Employer is different than above			City & State		Zip	Injury Date	
Auto <input type="checkbox"/> Yes <input type="checkbox"/> No			Address			City & State		Zip	Injury Date	
Other <input type="checkbox"/> Yes <input type="checkbox"/> No			Address			City & State		Zip	Injury Date	
REFERRED TO THIS PRACTICE BY										
Primary Care Physician							Phone Number			
Who Referred you to our office?										

I hereby give lifetime authorization for payment of insurance benefits to be made directly to **Jewett Orthopaedic Clinic**, and any assisting physicians for services rendered. I authorize treatment of the above listed patient by a provider at Jewett Orthopaedic Clinic. I agree that a photocopy of this agreement shall be valid as the original.

I understand that I may be seeing a Physician Assistant (PA) for my orthopaedic problem and that I have the choice of seeing a Physician at another time when an appointment is available. **Please initial if your appointment has been made with a PA** \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_