

**SALINA SPORTS MEDICINE AND ORTHOPEDIC CLINIC
NEW PATIENT REGISTRATION FORM**

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Sec #: _____ Sex: M/F _____ Birth Date: _____ Age: _____

Marital Status: Single Married Divorced Widowed

Home Phone: _____ Work Phone: _____

Phone: _____

Employer : _____ Cell Phone: _____

Emergency Contact

(Not in your household)

Relationship: _____ Home Phone: (____) _____ Work Phone: (____) _____

Primary Care Physician Phone #: (____) _____

Name: _____

Responsible Party or Bill To Information:

Full Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Birth Date: _____ Soc Sec. #: _____

Employer: _____ Work Phone: (____) _____

Primary Insurance (present card with form to be scanned)

Name: _____ Copay: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____ Policy ID#: _____

Group #: _____ Soc.Sec.#: _____

Effective : _____ Insurance Phone: _____

Secondary Insurance: (present card with form to be scanned)

Name: _____ Copay: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____ Policy ID#: _____

Group #: _____ Soc.Sec.#: _____

Effective : _____ Insurance Phone: _____

Injury: Yes No Work Comp: Yes No W/C Employer: _____

Date of Injury: _____ Address: _____

Explanation of Injury: _____

I verify the information provided is true and accurate and authorize Salina Sports Medicine and Orthopedic Clinic to contact any insurance, employer or guarantor listed to confirm or authorize treatment.

Patient Signature Date

Patient being seen for _____ (For Office Use Only)