ADVANCED CENTER
FOR SPORTS &
MUSCULOSKELETAL MEDICINE

# PATIENT REGISTRATION

## General Information

**NAME: LAST**_______________________________________**FIRST**__________________________**MIDDLE**______________
**DATE OF BIRTH**___________________________**SOCIAL SECURITY NUMBER**____________________________________
**SEX** □ **M** □ **F** **DRIVER'S LICENSE #**______________________________________**STATE**________________
**MARITAL STATUS:** □ **Married** □ **Single** □ **Divorced** □ **Widowed** □ **Domestic Partner**
**PARENT/GUARDIAN NAME**______________________________________**RELATIONSHIP**___________________________
**IN CASE OF EMERGENCY CONTACT**_______________________________________**PHONE**__________________________

## Addresses

**Home**
**STREET ADDRESS**_________________________________**CITY**___________________**STATE**________**ZIP**_____________
**HOME PHONE**__________________________________**CELL PHONE**____________________________________________
**EMAIL ADDRESS**________________________________________________________________________________

**Work**
**EMPLOYER**_____________________________________________________________________________________
**OCCUPATION**___________________________________________________________________________________
**WORK ADDRESS**_____________________________**CITY**______________________**STATE**________**ZIP**______________
**WORK PHONE**___________________________**WORK EMAIL ADDRESS**__________________________________________

## Insurance Information

**Primary Insurance**
**NAME OF PRIMARY INS CO**_______________________________________________**PHONE**________________________
**ID/POLICY NUMBER**______________________________________**GROUP NUMBER**________________________________
**NAME OF INSURED PERSON**________________________________**RELATIONSHIP**___________________**SEX**__________
**INSURED PERSON DOB**_____________________________________**INSURED PERSION SS#**_________________________
**EMPLOYER NAME**_____________________________________________**EMPLOYER PHONE**_________________________

**Secondary Insurance**
**NAME OF SECONDARY INS CO**______________________________________________**PHONE**_______________________
**ID/POLICY NUMBER**_____________________________________**GROUP NUMBER**__________________________________
**NAME OF INSURED PERSON**________________________________**RELATIONSHIP**___________________**SEX**__________
**INSURED PERSON DOB** ____________________________________**INSURED PERSON SS#**__________________________
**EMPLOYER NAME**___________________________________________**EMPLOYER PHONE**___________________________

**PHARMACY NAME**_________________________________**PHONE**_____________________**FAX**______________________

**PERSON WHO I AGREE TO RELEASE MEDICAL INFORMATION TO**_______________________**PHONE**________________
**PRIMARY CARE PHYSICIAN**___________________________________________________**PHONE**____________________

### RELEASE OF MEDICAL INFORMATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

Signature______________________________________________________________________Date____________________

□**Copy of insurance card (both sides) attached.** □**Updated by**____________________ **Date**____________________

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