Midwest Sports Medicine
& Orthopaedic Surgical Specialists, Ltd.

☐ Midwest Sports Medicine
☐ The Center for Physical Therapy
☐ Open MRI Imaging Specialists
☐ Midwest Center for Pain Management

REGISTRATION INFORMATION

I. PATIENT INFORMATION Social Security No.:_____
Legal Name:_____ Age: _____ Date of Birth:_____
Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Address: _____ City:_____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-mail Address: _____ Employer's/School Name: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Preferred Pharmacy Name: _____Pharmacy Phone: _____
Pharmacy Address: _____ City: _____ State: _____ Zip: _____
Preferred Language: _____ Ethnicity: ☐Hispanic or Latino ☐Non Hispanic or Latino ☐Other
Race: ☐Hispanic ☐Asian ☐Caucasian ☐Black or African American ☐American Indian or Alaska Native ☐Native American ☐Other

II. EMERGENCY CONTACT/PCP
In case of Emergency who should be notified? _____ Phone (___)_____ Relationship:_____
Who is your primary Dr?: _____ Phone: (___)_____ Address: _____

III. GUARANTOR INFORMATION *(If different from Patient)*
Legal Name:_____ Age: _____ Date of Birth:_____
Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Address: _____ City:_____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Social Security No.: _____
Driver's License No.: _____ Employer's Name: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

IV. PRIMARY INSURANCE INFORMATION
Name of Ins. Co.: _____ Policy ID No.: _____
Group No.: _____ Phone No.: _____ Co-Payment: $_____ Referral Needed: ☐Yes ☐No
If different than patient, fill in below:
Name of Policyholder: _____ Date of Birth: _____
Address: _____ City:_____ State: _____ Zip: _____
Social Security No.: _____ Employer: _____

V. SECONDARY INSURANCE INFORMATION
Name of Ins. Co.: _____ Policy ID No.: _____
Group No.: _____ Phone No.: _____ Co-Payment: $_____ Referral Needed: ☐Yes ☐No
If different than patient, fill in below:
Name of Policyholder: _____ Date of Birth: _____
Address: _____ City:_____ State: _____ Zip: _____
Social Security No.: _____ Employer: _____

VI. WORKER'S COMPENSATION OR LEGAL/ACCIDENT (If applicable)
Name of Carrier: _____
Address: _____ City:_____ State: _____ Zip: _____
Phone No.: _____ Claim No.: _____ Name of Adjuster: _____
Employer at Time of Accident: _____ Phone No.: _____
Name of Attorney: _____ Phone No.: _____
Verification of W/C: ☐ YES ☐ NO Date Made: _____ by: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage and assign directly to Midwest Sport Medicine & Orthopaedic Surgical Specialists, Ltd. and its affiliates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my health care information and such information to the above-named Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services. This consent will end upon termination of coverage with the above-named Insurance Company(ies) or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Please print name or Patient, Parent, Guardian or Personal Representative

_____ _____ Account No._____
Date Relationship to Patient (*For Office Use Only)*