OPA ORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

PATIENT REGISTRATION

Patient Name: _____ Gender: ☐ Male ☐ Female
Last First Middle Initial

Mailing Address: _____ Home Phone: _____
Street Apt. #

City: _____ State: _____ Zip: _____ Day/Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Widow/er

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ Asian ☐ American Indian or Alaska Native ☐ Unknown ☐ Other ☐ Prefer not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Prefer not to disclose

Preferred Language: _____ Email: _____

Birthdate: _____/_____/_____ Age: _____ Social Security #: _____

Primary Care Physician: _____

Referred by Dr./Other: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE

Insurance Company Name: _____

OTHER INSURANCE

Insurance Company Name: _____

BILLING INFORMATION
(Complete if person responsible for bill is not the patient.)

Name of person responsible for bill: _____
D.O.B. Relationship Social Security #

Address (if not as above): _____
Street City State Zip

Phone: _____ Employer: _____

INFORMATION ABOUT YOUR CONDITION

What part of the body are you being seen for today? _____ ☐ L ☐ R
Is this a result of a work or auto injury? ☐ Yes ☐ No If **yes**, please complete the following:

Date of Injury: _____ /_____ /_____ Claim Number: _____

Workers' Compensation Billing Address: _____
Street City State Zip

Claim manager name: _____ Phone: _____

I authorize my insurance benefits to be paid to Orthopedic Physician Associates and I understand I am financially responsible for any unpaid balance. I authorize the physician or insurance company to release any information required for this claim. OPA may send you non-personally identified communication to assess your satisfaction with our services. You may opt out of such communication at any time.

Signature _____ Date _____