Adult & Pediatric Orthopedics, S.C.
PATIENT REGISTRATION FORM

Today's Date:_____ Date of Birth: _____ Age:_____

Patients Name: _____ Height:_____Weight:_____

☐Male ☐Female ☐Right Handed ☐Left Handed ☐Ambidextrous

Address:_____
Street

_____
City **State** **Zip Code**

Cell Phone Number:_____ Home Phone Number:_____

Email Address: _____ Work Phone Number: _____

Employer:_____ Employer's Phone Number:_____

Employer's Address:_____

Emergency Contact:_____ _____ Phone Number: _____
Relationship to Patient

Insurance Information

Primary Insurance
Company Name:_____ ID Number:_____ Group Number:_____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____

Secondary Insurance
Company Name:_____ ID Number:_____ Group Number:_____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____

Primary Care Doctor: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Reason for Today's Visit/Body Part Injured: _____

Date Symptoms Began: _____

How Did Injury Occur? _____

Is this a work-related injury? □ Yes □ No Is this a personal injury that occurred outside of work? □ Yes □ No

Do you have an attorney for this injury? □ Yes □ No

Attorney's Name: _____ Attorney's Phone Number: _____

Attorney's Address _____
Street State Zip

If X-rays, MRI or other tests have been obtained please state when and where:_____

List Current Medications:	

Do you have any Allergies (Medications or Environmental)? _____

Current and Past Medical Problem List	Date	Past Surgical History	Date

Family History of

Y	N		Family Member
☐	☐	Alzheimer's Disease	_____
☐	☐	Coronary Artery Disease	_____
☐	☐	Cerebrovascular Disease	_____
☐	☐	Depression	_____
☐	☐	Diabetes	_____
☐	☐	Glaucoma	_____
☐	☐	High Cholesterol	_____
☐	☐	High Blood Pressure	_____
☐	☐	Breast Cancer	_____
☐	☐	Cervical Cancer	_____
☐	☐	Colon Cancer	_____
☐	☐	Ovarian Cancer	_____
☐	☐	Prostate Cancer	_____
☐	☐	Skin Cancer	_____
☐	☐	Thyroid Disease	_____
☐	☐	Rheumatologic Condition	_____
☐	☐	Other: _____	_____

Social History

☐ Married ☐ Single ☐ Civil Union
☐ Divorced ☐ Widow(er)
☐ Lives Alone ☐ Separated

Occupation: _____

☐Full Time ☐Part Time ☐ Retired ☐ Student

Do you smoke? ☐ Yes ☐ No Packs per day ___

Do you drink alcohol? ☐Yes ☐ No
Drinks per week_____

Work activity: ☐ Sitting ☐Standing
☐Light Labor ☐ Heavy Labor

Do you exercise? ☐ Yes ☐No

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Adult & Pediatric Orthopedics, S.C. 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date:_____

Authorization

I/we hereby voluntarily consent to examination, diagnosis, treatment, x-rays and/or surgical procedures and I/we hereby release Adult & Pediatric Orthopedics, S.C., Dr. Jay L. Levin, Dr. David M. Zoellick, Dr. David A. Schafer, Dr. Martin P. Lanoff, Jeffrey Bell, PA-C, and other physicians of the practice from any liability as a result of such examination, diagnoses, x-rays, treatments and/or surgical procedures.

Signature of PATIENT/(Guardian): _____ Date:_____