JEFFERSON ORTHOPEDIC CLINIC **Patient Registration Form**

L. Thomas Cashio, M.D. | Barton L. Wax, M.D. | Matthew R. Grimm, M.D.
Mark Juneau, Jr., M.D. | Wesley A. Clark, M.D. | R. Douglas Bostick, III, M.D.

Today's Date: _____ / _____ / ______

Preferred Doctor: Dr. Juneau   Dr. Cashio   Dr. Grimm   Dr. Bostick   Dr. Wax   Dr. Clark

Preferred Pharmacy: Name: _________________________ Phone # ________________ Fax # ________________

Pharmacy Adress: ____

Patient:
Last Name: _________________________ **First:** _________________________ **M.I.** ___________

Preferred Name: _________________________ **Maiden Name**: _________________

Date of Birth: _____ / _____ / ______ **Sex:** M   F   Other   **SSN:** _________ - _______ - ___________

Race: American Indian   Asian   Black–African American   National Hawaiian Pacific Islander   White   Other Race

Marital Status: Annulled   Common Law   Domestic Partner   Interlocutory   Legally Separated
Register Domestic Partner   Single   Married   Unmarried   Widowed

Drivers License# ___________________ **State:** _________________

Primary Languange: Arabic   Chinese   English   Filipino   French   German   Greek   Hindi   Italian   Japanese
Korean   Other   Polish   Portuguese   Russian   Spanish   Vietnamese

Religion: Buddhist   Catholic   Hindu   Islam   Jewish   Other   Protestant   Unknown

Ethnicity: Hispanic or Latino   Not Hispanic or Latino   Declined   Unknown

Home Street Address: ____

City: _________________________________ **Parish:** ________________ **State:** _________ **Zip**: __________

Country: United States   Canada   Mexico   Unknown   Other ________________

Phone: Home#: __________________ Primary Work# _______________________

Cell# ____________________ Primary Contact # _____________________

Fax# ___________________ EMAIL: ____

Preferred Communication: Home#   Primary Work#   Cell#   Fax#   Email   Mail   Patient Portal

Are You Employed: Yes   No   Full   Part-Time   **Are you a student:** Yes   No   Full Time   Part-time

Reason for visit: ____
Work Accident   Accident   Sports Injury   Recurring Illness   Other

If an accident, Date of Accident: _____ / _____ / ______ **Place of accident:** ___________________________________

Did you go to the hospital? Yes   No   If Yes, What Hospital did you go to: ___________________________

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Employer (or Parents Employer)

Name of Company: ________________________________ Work Phone ________________________

Occupation: ____

Address: ____

City: ____________________________________ State: ____________________ Zip: ______________

Emergency Contact (Friend or Relative not living with you)

Name of Contact: ______________________________ Phone/ Cell / Pager (_____)_______________

Your relationship to emergency contact: ____

Spouse Information

Spouse's Name: ________________________________ Phone / Pager: __________________________

Employer: _____________________________________ Work Phone: ___________________________

Insurance Information (Give insurance card and Drivers License to receptionist)

Insured Name: ____

Primary Insurance: ___________________________ Policy or ID#: ______________________________

Mailing address: _____________________________ City: _________________ State _______ Zip _______

Name of Insured: ____________________________ Group Name: ______________ Group# ___________

Secondary Insurance Information (Give insurance card to receptionist)

Secondary Insurance: ___________________________ Policy or ID#:____________________________

Mailing address: _____________________________ City:_________________ State _______ Zip _______

Name of Insured: ____________________________ Group Name: ______________ Group# ___________

CONSENT FOR TREATMENT: I as a patient consent to medical care including examination, diagnostic, or surgical treatment by the treating physician and such associates or assistants as may be deemed necessary. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of any treatment.

Patient Signature:________________________________ **Date:** ______/_______/________

AUTHORIZED RELEASE OF INFORMATION: I hereby authorize Jefferson Orthopedic Clinic to release those medical records pertaining to my treatment to any entity that is responsible for payment of physician charges. I understand that this authorizes my insurance company to pay any benefits directly to Jefferson Orthopedic Clinic. In addition, I further understand that I am ultimately responsible for charges incurred for services rendered, and that collection fees will be added to balance not paid in a timely manner.

Patient Signature: ________________________________**Date:** _____/_______/_________