

JEFFERSON ORTHOPEDIC CLINIC

Patient Registration Form

Mark Juneau, Jr., M.D.
Matthew R. Grimm, M.D.

Wesley A. Clark, M.D.
Barton L. Wax, M.D.

Scott A. Tucker, M.D.
John M. Kesler, PA-C

Today's Date: ____ / ____ / ____

Preferred Doctor: Dr. Juneau Dr. Grimm Dr. Clark Dr. Wax Dr. Tucker John Kesler

Preferred Pharmacy: Name: _____ Phone # _____ Fax # _____

Pharmacy Address: _____

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 Language: 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: _____

JEFFERSON ORTHOPEDIC CLINIC

Patient Registration Form

Mark Juneau, Jr., M.D.
Matthew R. Grimm, M.D.

Wesley A. Clark, M.D.
Barton L. Wax, M.D.

Scott A. Tucker, M.D.
John M. Kesler, PA-C

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:** ____/____/____