SOUTHWEST SHOULDER ELBOW & HAND CENTER

Patient Registration Form

☐ Dr. Beer ☐ Dr. Butler ☐ Dr. Chafik
☐ Dr. FitzPatrick ☐ Dr. Jain ☐ Dr. Siegel

Date:_____ Account # _____

Internal Use

PATIENT INFORMATION		
Last Name	First Name	Middle Name
Mailing Address:		
City:	State:	Zip:
Physical Address (if different)		
Home Phone: ( )_____ Work Phone ( ) _____ Cell Phone ( ) _____		
Date of Birth:	Age:	Social Security Number:
Marital Status: (circle one) S M D W LP		Spouse's
Employer:	Occupation:	
Patient Email:		
Preferred Pharmacy:		
Is this related to a work injury? ☐ **NO** ☐ **YES** **IF YES – PLEASE FILL OUT THE WORKER'S COMP INFORMATION ON NEXT PAGE**		

GUARANTOR INFORMATION		
Relationship to Patient: ☐ Self/Same ☐ Spouse ☐ Parent or Guardian		
Last Name	First Name	Middle Name
Mailing Address:		
City:	State:	Zip:
Home Phone: ( )_____ Work Phone ( ) _____ Cell Phone ( ) _____		
Date of Birth:	Age:	Social Security Number:

EMERGENCY CONTACT	
Relationship to Patient: _____	
Last Name	First Name
Home Phone: ( )_____ Work Phone ( ) _____ Cell Phone ( ) _____	

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RACE/ETHNICITY
Race: ☐ Asian ☐ Black/African American ☐ Native American ☐ White/Caucasian ☐ Other _____
Ethnicity: Do you identify with an Ethnic Origin? If Yes please note:_____

INSURANCE INFORMATION		
☐ Self Pay ☐ Insurance ☐ Workman's Comp ☐ Auto/Homeowner's Liability * ☐ Other _____ *Southwest Shoulder Elbow and Hand does not bill third party liability.*		
Primary Insurance		ID# Group# HMO ☐ PPO ☐ POS ☐
Claims Address:		
City:	State:	Zip:
Subscriber Name:	Relationship to Patient:	
Date of Birth:	Social Security Number:	

Secondary Insurance		ID# Group# HMO ☐ PPO ☐ POS ☐
Claims Address:		
City:	State:	Zip:
Subscriber Name:	Relationship to Patient:	
Date of Birth:	Social Security Number:	

WORKERS COMP INFORMATION		
Employer at time of injury		Date of Injury
Insurance Carrier:		
Claims Address:		
City:	State:	Zip:
Adjuster's Name:	Adjuster Phone:	
Claim #		

I understand that it is my responsibility to provide accurate insurance information for billing purposes and that any denial due to information not being provided will result in the financial responsibility of the patient and/or guarantor.

Patient/Guarantor Signature:_____Date:_____