Rapides Orthopedic Clinic

Patient Registration Form

Patient's Demographic Information

Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip:
Home Phone: ( )	Mobile Phone: ( )	Work Phone: ( )
Date of Birth:	SS#:	Gender: ( ) Male ( ) Female
Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed		
In Case of an Emergency, who should we notify?		
Name:	Phone Number:	Relationship:
Are you currently employed: ( ) Yes ( ) No ( ) Full-Time ( ) Part-Time		
If so, where are you employed:	What is your occupation?	
Employer's Address:		
Are you a student: ( ) Yes ( ) No ( ) Full-Time ( ) Part-Time		
If so, where do you attend school:		
Do you participate in organized Sports? If so, which ones?		
Who can we thank for referring you to our clinic?		

Insurance Information

Even though we have copies of your cards, this section must be filled out in completion

Policy Holder's Employer:		Employer's Phone Number:	
Primary Insurance Company:			
Name of Policy Holder:	Policy Holder Date of Birth	Policy Holder SS#	Relationship:
Secondary Insurance Company:			
Name of Policy Holder:	Policy Holder Date of Birth	Policy Holder SS#	Relationship:
Other Health Insurance Company:			
Name of Policy Holder:	Policy Holder Date of Birth	Policy Holder SS#	Relationship:

Guarantor Information

If the patient is under 18 years of age, we must receive the following information for the person who brought them here today.

Name of Guarantor:	Guarantor's Date of Birth	Guarantor's SS#	Relationship:
Mailing Address for Guarantor:			
Guarantor's Employer:		Guarantor's Work Phone Number	

Today's Date: _____