Midwest Orthopaedics at RUSH

Patient Registration Form

Patient information

Last Name	First Name	Middle

Address	City	State	Zip Code

Social Security Number / /	Date of Birth_____/_____/_____ mm dd yyyy	Age	Sex F M	Marital Status S M W D

Language Preference:
☐ Polish ☐ Spanish ☐ Other _____
☐ Hearing Impaired

Race: ☐ African American ☐ Asian ☐ American Indian ☐ Hispanic ☐ Other ☐ Pacific Islander ☐ White

Please rank from 1 to 6 your preferred method of contact. Exclude those you would not like us to use.

May we send reminders to your first choice? ☐ Yes ☐ No

___ Home Phone:_____
___ Work Phone:_____
___ Cell Phone:_____
___ Work E-Mail:_____
___ Personal E-Mail:_____
___ Other E-Mail:_____

Occupation	Employer	Employer Telephone ( )

Employer Address:	City	State	Zip Code

Contact person	Reason for Appointment	What Side of Body? ☐Left ☐Right	Date Symptom Began

Referring Physician	Referring Physician Telephone ( )

Address	City	State	Zip Code

Primary Care Physician (PCP)	Primary Physician Telephone ( )

Address	City	State	Zip Code

Health Insurance

Primary Insurance	Policy Number: Group/ID Number:

Last Name	First Name	Middle Name

Date of Birth_____/_____/_____ mm dd yyyy	Social Security Number / /	Insurance Phone Number: ( )

Employer Name:	Business Telephone ( )

Employer Address:	State	Zip Code	Contact Person

Secondary Insurance	Policy Number: Group/ID Number:

Last Name	First Name	Middle Name

Date of Birth_____/_____/_____ mm dd yyyy	Social Security Number / /	Insurance Phone Number: ( )

PLEASE READ AND COMPLETE SECTIONS ON REVERSE SIDE

Guarantor/ Legal Guardian. Complete if Different from Above			
☐Parent	☐Legal Guardian:	☐Other	
Last Name	First Name	Relationship	
Home Phone ( )	Guarantor Social Security / /	Guarantor Birth Date_____/_____/_____ mm dd yyyy	
Address	City	State	Zip Code

Workers Compensation Information			
Work related injury ☐YES ☐NO	If yes, date of accident:		
Name of Worker's Compensation Carrier	Claim Number		
What Part of the body was Injured?			
Address	City	State	Zip Code
Phone Number ( )	Date Last Worked:		
Adjuster's Name:	Phone Number: ( )		

Accident Information			
Motor vehicle / Personal related injury ☐YES ☐NO	If yes, date of accident:		
Motor Vehicle Compensation Carrier	Claim Number		
Address	City	State	Zip Code
Phone Number: ( )	Date last worked:	State Where accident occurred:	

Attorney Information			
Attorney's Name (if lawsuit is involved)	Phone Number: ( )		
Address	City	State	Zip Code

Emergency Contact (Note: Different from your home information)	
Name	Relationship
Home Telephone ( )	Work Telephone ( )

How did you find out about Midwest Orthopaedics at Rush?	
☐Family / Friend / Relative	☐Sports Team
☐MOR/ RUSH Employee	☐Workman Comp./ Case Manager
☐Physician/ MD / DO	☐Yellow Pages
☐Other Healthcare Provider	☐Website
☐Others (Specify	

_____ _____

PATIENT SIGNATURE **DATE**

All the information provided above are complete and accurate to the best of my knowledge.

Photo ID, insurance card and co-pay are required on day of visit. If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility. All unpaid balances and or denied claims are your responsibility.