



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: <input type="checkbox"/> Polish <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Hearing Impaired			Race: <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
___ Home Phone: _____			___ Work E-Mail: _____						
___ Work Phone: _____			___ Personal E-Mail: _____						
___ Cell Phone: _____			___ Other E-Mail: _____						
Occupation			Employer			Employer Telephone ()			
Employer Address:				City			State		Zip Code
Contact person		Reason for Appointment			What Side of Body? <input type="checkbox"/> Left <input type="checkbox"/> 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				
<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian:	<input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> 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?				
<input type="checkbox"/> Family / Friend / Relative		<input type="checkbox"/> Sports Team		
<input type="checkbox"/> MOR/ RUSH Employee		<input type="checkbox"/> Workman Comp./ Case Manager		
<input type="checkbox"/> Physician/ MD / DO		<input type="checkbox"/> Yellow Pages		
<input type="checkbox"/> Other Healthcare Provider		<input type="checkbox"/> Website		
<input type="checkbox"/> 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.