



Midwest
Orthopaedics
at RUSH

Patient Registration Form

Dr. _____

PLEASE PRINT

Date _____

PATIENT INFORMATION	Last Name		First Name		Middle	
	Address			Home Telephone ()		
	City		State/Zip Code	Work Telephone ()		
	E-Mail		Pager Number ()	Cell Telephone ()		
	Social Security Number / /	Birth Date ____ / ____ / ____ MM DD YYYY		Age	Sex (circle one) F M	Marital Status (circle one) S M W D
	Occupation	What part of the body was injured? Left Side Right Side		Date of Injury/Onset		
	Primary Physician			Primary Physician Telephone ()		
	Primary Physician Address					
	Referring Physician			Referring Physician Telephone ()		
	Referring Physician Address					

GUARANTOR & INSURANCE INFORMATION (Person who has insurance)	Responsible Party for this account or Custodial Parent. Complete if Different from Above				
	Last Name		First Name		Relationship
	Address		Guarantor Social Security / /	Guarantor Birth Date ____ / ____ / ____ MM DD YY	
	Insurance				
	Primary Insurance			Policy Number: Group/ID Number:	
	Street Address			Insurance Telephone ()	
	City		State/Zip Code	Contact Person	
	Secondary Insurance			Policy Number: Group/ID Number:	
	Street Address			Insurance Telephone ()	
	City		State/Zip Code	Contact Person	
<p>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.</p>					

PLEASE READ AND COMPLETE SECTIONS ON REVERSE SIDE

