



1050 Reid Parkway, Suite 325
 Richmond, Indiana 47374
 (765) 935-8905 Fax: (765) 935-8906

ARRIVAL TIME:	TODAY'S DATE:	PRIMARY CARE PHYSICIAN:	
PATIENT INFORMATION			
PATIENT'S LAST NAME:	FIRST:	MIDDLE:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
MAIDEN NAME:	BIRTH DATE:	AGE:	MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
HOME PHONE # OR MESSAGE PHONE: ()	SOCIAL SECURITY #:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
STREET ADDRESS:			P.O. BOX #:
CITY:	STATE:	ZIP CODE:	
PATIENT'S E-MAIL ADDRESS (for in-office and educational purposes only):			
EMPLOYER:	EMPLOYER ADDRESS:		EMPLOYER PHONE #:
Are you being seen due to an injury: <input type="checkbox"/> Yes <input type="checkbox"/> No	If so please list date of injury:	If so please list time of injury:	
HOW DID YOU HEAR ABOUT REID ORTHOPEDICS			
<input type="checkbox"/> Billboard <input type="checkbox"/> Newspaper Ad / Printed Material <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Website <input type="checkbox"/> Family or Friend Name of Physician who referred you: _____ Other: _____			
IN CASE OF EMERGENCY			
NAME OF EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:	HOME PHONE #:	WORK PHONE #:
INSURANCE INFORMATION – (Please give insurance card(s) to receptionist.)			
PERSON RESPONSIBLE FOR BILL:	BIRTH DATE:	HOME PHONE #:	
ADDRESS (if different from above):			
EMPLOYER:	EMPLOYER ADDRESS:		EMPLOYER PHONE #:
PLEASE INDICATE PRIMARY INSURANCE: (Please provide card(s) to receptionist.)	<input type="checkbox"/> Commercial Insurance <input type="checkbox"/> Workman's Compensation	<input type="checkbox"/> Self Pay <input type="checkbox"/> Medicare	<input type="checkbox"/> Tri-Care <input type="checkbox"/> Medicaid
NAME OF PRIMARY INSURANCE:			
SUBSCRIBER'S NAME:	SUBSCRIBER'S SOCIAL SECURITY #:	SUBSCRIBER'S BIRTH DATE:	
GROUP #:	POLICY #:	CO-PAYMENT: \$	
PATIENT'S RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			
NAME OF SECONDARY INSURANCE (if applicable):			SUBSCRIBER'S NAME:
GROUP #:	POLICY #:	CO-PAYMENT: \$	
PATIENT'S RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			

**REID ORTHOPEDICS
 REGISTRATION FORM**

PTITIN



PATIENT LABEL