BERKSHIRE ORTHOPAEDIC ASSOCIATES - PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT NEATLY)

FIRST NAME:___________________________________ LAST NAME:____

IF MINOR, RESPONSIBLE PARTY IS: ____

DOB:_________________________________ SEX: (M/F) __________________ SOCIAL SECURITY #: _________________________________

STREET ADDRESS: ____

CITY:____ STATE:__________________ ZIP CODE: _________________

MAILING ADDRESS IF DIFFERENT THEN ABOVE: ____

HOME PHONE: ___________________________________ WORK PHONE: ____

CELL PHONE: ____________________________________

BODY PART BEING TREATED FOR TODAY: _________________________________ DATE OF INJURY: ________________________

NAME OF EMPLOYER: ____

OCCUPATION: ____

THE FOLLOWING INFORMATION IS NOW A FEDERAL MANDATE: PLEASE ANSWER ALL THREE QUESTIONS

RACE: ☐ DECLINE ☐ WHITE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/ OTHER PACIFIC ISLAND

☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ OTHER: ___________________________________

ETHNICITY: ☐ DECLINE ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: ________________________

PLEASE COMPLETE IF THIS IS A MOTOR VEHICLE ACCIDENT, WORKERS COMPENSATION CASE OR A LIABILITY CASE

IS THIS RELATED TO WORKER'S COMPENSATION ☐ YES ☐ NO

WORKER'S COMP CLAIM # :____ DATE OF INJURY: ________________________________

WORKER'S COMP INSURANCE CARRIER:____

IS THIS RELATED TO AN AUTO ACCIDENT: ☐ YES ☐ NO

AUTO INSURANCE CLAIM# : ____ DATE OF INJURY: ________________________________

AUTO INSURANCE CARRIER: ____

IS THIS RELATED TO ANY OTHER TYPE OF LIABILITY CASE? ☐ YES ☐ NO DATE OF INJURY: ________________________________

IF SO PLEASE EXPLAIN: ____

IF YOU HAVE ENTERED YES TO ANY OF THE ABOVE, DO YOU HAVE AN ATTORNEY REPRESENTING YOU FOR YOUR CLAIM ☐ YES ☐ NO

NAME OF ATTORNEY: ____ PHONE NUMBER: ________________________________

STREET ADDRESS: ____

CITY, STATE, ZIP: ____