Patient Registration Form   Family Practice & Orthopedic Care Center, PC / Omega PT

Name ____
First   MI   Last

Address ____
Street or PO Box
____
City   State   Zip Code

Is this your permanent address? If not, include your permanent address: ____
____

Primary Phone ____

Secondary Phone ____

Email Address: ____

Emergency Contact: ____

Phone # ____

Are you a student? Yes / No   If yes, full time / part time

Primary Insurance

Name of Insurance: ______________________________

ID# ________________________ **Group#**______________

Cardholder: ______________________________

Cardholder DOB: _____/_____/__________

Cardholder SSN: _______-_____-________

Relationship to patient: ______________________________

Cardholder address if different from above:

____
____

Responsible Party: ______________________________
DOB:______________ **SSN** ________-_____-_______
Address: (**if different than above)**
____
____

Phone #: ____

Is this visit related to an Auto or Work Incident?___
If yes, please provide the following information:
Send Claims to: ______________________________
____
____
Adjuster:______________________________
Phone:______________________Fax ______________
Email ______________________________

Date of Loss/Injury: ______________________
Claim Number:______________________________

SSN _______-____-_________ **DOB** ____/_____/________

Circle Correct Answers below:
Gender: Male Female
Race: American / Indian /Hispanic / Arabic / African-American Other:
Ethnicity: Caucasian / Hispanic / African / Asian/ Indian Middle Eastern Other:
Language Spoken: English Spanish ______________

Single   Married   Widowed   Divorced

Primary Care Physician: ____________________________
Telephone # ____________________________

Preferred Pharmacy ____________________________
City/Town ____________________________

Employer Info: ____________________________
Work Phone ____________________________

Secondary Insurance

Name of Insurance: ______________________________

ID#________________________**Group#**______________

Cardholder: ______________________________

Cardholder DOB: _____/_____/__________

Cardholder SSN: _______-_____-________

Relationship to patient: ______________________________

Cardholder address if different from above:

____
____

Is your Insurance coverage purchased by Marketplace Exchange/Affordable Care Act? _______________

If purchased through an exchange, please indicate the state which you purchased coverage? ____________

PLEASE NOTE: If your exchange plan is OUTSIDE the state of Michigan, your services will *NOT* be covered in our office.

Statements for patient responsibility/co insurance are sent monthly (every 30 days). **Effective June 1, 2015, there will be a Billing Fee of $5.00 on unpaid balances greater than 60 days.**

$25.00 No Show Charge for appointments missed without prior notification or cancellation.