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 mailing address? If not, include your mailing address:

_____

_____

Preferred 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 Other

Race/Ethnicity: White / African American / Asian / Indian Hispanic / Arabic / Pacific Islander / Other:

Language Spoken: _____

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.