

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: _____

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 at Birth: Male Female

Gender Identity: Male Female Transgender

Gender Non-Binary Not Listed _____

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:

If Insurance is purchased through a Marketplace 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.