KENTUCKIANA HAND SURGERY
PEDIATRIC ORTHOPAEDICS
KENTUCKIANA FOOT & ANKLE

PATIENT REGISTRATION

SO-25 (Rev. 9-10-05)

Date _____

PATIENT INFORMATION

Name (Last) (First) (MI) Birth Date Age Sex: ❑ Male ❑ Female

Soc. Sec. # Home Phone ( ) Cell Phone ( ) If Married, Spouse Name

Address City ST Zip

Employer Employer Phone ( )

If Patient is a Child, Name of Mother (Last) (First) (MI) Child Lives With

If Patient is a Child, Name of Father (Last) (First) (MI)

In Case of Emergency, Contact (Someone in another household, i.e., grandparent, friend, etc.) Name Relationship to Patient

Home Phone Work Phone Address City ST Zip

PRIMARY PHYSICIAN AND REFERRAL INFORMATION

Primary Physician / Pediatrician:

Name(Last) (First) (MI)

Address

City ST Zip

Phone ( ) Fax ( )

Referred by? (Physician, Family Member, Friend, etc.):

Name(Last) (First) (MI)

Address

City ST Zip

Phone ( ) Fax ( )

INJURY RELATED INFORMATION

If Accident / Work Comp. Check Box Below and **MUST COMPLETE BACK OF FORM:**

Date of Injury Month Day Year ❑ Work Related ❑ Auto ❑ Motorcycle ❑ Other

Please give attorney name, etc. if one has been contacted regarding this injury.

Name(Last) (First) (MI Phone ( ) Fax ( )

Address City ST Zip

PRIMARY INSURANCE INFORMATION

Person Resp. for Acct. Employer Wk Phone

(If Different From Patient) Address City ST Zip Hm Phone

Name of Ins. Co **Subscriber's Name** (Last) (First) (MI)

Subscriber's Soc. Sec. # **Subscriber's Birth Date** Pat. Relationship to Subscriber

Policy # or ID Number Group # Eff. Date

Address City ST Zip

SECONDARY INSURANCE INFORMATION

Name of Ins. Co **Subscriber's Name** (Last) (First) (MI)

Subscriber's Soc. Sec. # **Subscriber's Birth Date**

PLEASE PROVIDE THE RECEPTIONIST WITH ALL INSURANCE / BILLING INFORMATION.

SPECIALTY ORTHOPAEDICS, P.S.C.

INJURY RELATED INFORMATION

WORKMANS COMP. INFORMATION Date of Injury

(Patient Fill Out) Patient Date of Birth

Employer

Address

City ST Zip

Phone ( ) Fax ( )

Contact Name

AUTO ACCIDENT INFORMATION Date of Injury

(Patient Fill Out) Patient Date of Birth

Insured

Insurance Co.

Address

City ST Zip

Phone ( ) Fax ( )

Agent Name

Policy #

FOR OFFICE USE ONLY

W/C Carrier

Address

City ST Zip

Phone ( ) Fax ( )

Claim #

Adjuster

FOR OFFICE USE ONLY

Carrier

Claims Address

City ST Zip

Phone ( ) Fax ( )

Claim #