Patient Registration Form

PATIENT INFORMATION

(Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other______________

Patient's Name (Last)______________________________ (First)________________________ (Middle)________________

Also Known As Name (Last)____(First)______________________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _______-_____-_______ ☐ Female ☐ Male Date of Birth______/______/______

E-Mail Address____

Phone Numbers Home____________________ ☐ Day ☐ Evening Work____________________ ☐ Day ☐ Evening

Cellular__________________ Pager_____________ May we contact you at work? ☐ Yes ☐ No

Address____

City, State, ZIP (+4)____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer____ Occupation_______________________________

Emergency Contact Name____ Phone Number___________________________

Relationship to Patient____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____________________ (First)________________________ (Middle)________________

Also Known As Name (Last)____(First)______________________________

Social Security Number _______-_____-_______ ☐ Female ☐ Male Date of Birth______/______/______

E-Mail Address____

Phone Numbers Home____________________ ☐ Day ☐ Evening Work____________________ ☐ Day ☐ Evening

Address____

City, State, ZIP (+4)____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer____ Employer Phone Number_________________________

Patient Relationship to Responsible Party____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured____ Patient Relationship to Insured__________________

Insurance Company/Phone Number____ (_______)________________

Subscriber ID (Policy Number)___________________ Group ID__________________ Copay Amount___________________

Effective Date_____________________ Termination Date_______________________ ☐ Female ☐ Male

Insured Date of Birth_______/_______/_______ Insurance Company Address____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured____ Patient Relationship to Insured__________________

Insurance Company/Phone Number____ (_______)________________

Subscriber ID (Policy Number)___________________ Group ID__________________ Copay Amount___________________

Effective Date_____________________ Termination Date_______________________ ☐ Female ☐ Male

Insured Date of Birth_______/_______/_______ Insurance Company Address____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____ ***Date***________________

Dear Patient,

We would like to take this opportunity to welcome you to our practice and notify you of some things that would help us to serve you better.

1. If your insurance requires a referral to see Dr. Yakel, please verify with your primary care physician that the referral has been done and a copy sent to our office.

2. Enclosed with this letter you will find a packet of information. Please complete these forms PRIOR to your first appointment. Bring the above forms, insurance cards, and a list of all medications (including over the counter medications and vitamins) with you to your appointment.

3. We request that any information or testing that has been performed in the past be brought with you to your appointment. This should include films of any X-rays, MRIs, Catscans, Mylograms, etc.

ALL NEW BACK PATIENTS must have routine back x-rays that have been taken within the past six months. If you do not have these, you may contact our office and x-rays can be ordered for you prior to your appointment. Each patient will be responsible for bringing their own FILMS with them.

Your appointment may have to be rescheduled if we do not have access to the actual films.

Thank you for your attention to these matters. We look forward to meeting with you.

If you have any questions please call our office at 540-382-6613 and we will be happy to assist you.

Sincerely,
Southwest Virginia Orthopedic and Spine

Appointment:
Date and Time:______________________________
Arrival Time:_______________________________