Anderson Orthopaedic Clinic
Patient Registration & Demographics

Patient Name: _____ **DOB:**_____ **SSN:**_____ **Sex:** ☐ F ☐ M

Address:_____ **City:**_____ **State:**_____ **Zip**:_____

Preferred Phone Number: _____ **(Home Work Cell)** **Alternate Phone:** _____ **(Home Work Cell)**

Email Address:_____ **Alternate Phone:** _____ **(Home Work Cell)**

Race:_____ **Ethnicity:**_____ **Preferred Language:**_____

Preferred Pharmacy Name:_____ **Phone:**_____ **Address:**_____

What was the onset date of your symptoms? _____

Were you referred by a physician? ☐ Y ☐ N **If yes, who?**_____ **Phone:** _____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

If no, how did you hear about Anderson Clinic? ☐Former Patient (Family/Friend) ☐Family/Friend (not a former patient) ☐AOC website

☐ Physical Therapist ☐ External Ratings Website (Healthgrades, Angie's List, etc.) ☐ Other:_____

Emergency Contact: _____ **Relationship:**_____

Phone: _____ **(Home Work Cell)** **Phone:** _____ **(Home Work Cell)**

Guarantor/ Person Responsible for Bill: _____ **Relationship:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

SSN: _____ **Sex:** _____ **Phone:** _____ **(Home Work Cell)** **Phone:** _____ **(Home Work Cell)**

Primary Insurance Company:_____ **Phone:** _____

Policy #: _____ **Group #:** _____ **Other #:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Insured/Policy Holder's Name: _____ **Relationship:** _____ **D.O.B.:**_____

Is Insurance Employer Sponsored?: ☐ Y ☐ N **If yes, what Employer?:**_____

Secondary Insurance Company:_____ **Phone:** _____

Policy #: _____ **Group #:** _____ **Other #:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Insured/Policy Holder's Name: _____ **Relationship:** _____ **D.O.B.:**_____

Is Insurance Employer Sponsored?: ☐ Y ☐ N **If yes, what Employer?:** _____

Workers' Compensation Carrier:_____ **Phone:** _____

Claim #: _____ **Date of Injury:** _____ **Fax #:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Case Manager/Adjuster: _____**Phone:**_____