ProOrtho
a division of
PROLIANCE SURGEONS INC., P.S.

Date:

PATIENT REGISTRATION

Patient Name____
Last First Middle Initial (Nickname)

Home Address____
Street Apt#

____
City State Zip

( ) Male ( ) Female Body part being evaluated_______________________________

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widow/er

Birth date: ___/___/_____ Age: ______ Social Security # __________________________

LANGUAGE: __________________________

RACE: ( ) American Indian or Alaskan Native ( ) Asian ( ) Black or African American
( ) Native Hawaiian or Pacific Islander ( ) White or Caucasian ( ) Decline

ETHNICITY: ( ) Hispanic or Latino ( ) Non- Hispanic or Latino ( ) Decline

Primary Phone ( ) _________________________ Okay to Leave Message? ( ) Y ( ) N

Secondary Phone ( ) _________________________ Okay to Leave Message? ( ) Y ( ) N

Emergency Contact _______________________ Emergency Phone ( ) _________________

Okay to Speak With? ( ) Y ( ) N

Emergency Contact _______________________ Emergency Phone ( ) _________________

Okay to Speak With? ( ) Y ( ) N

E-mail __________________________________ Okay to send detailed message? ( ) Y ( ) N

We occasionally E-mail company newsletters. If you wish to opt out of these, please check here ☐

Primary Care Physician: ______________________________ Phone # ( )_____________

Referred by (Dr./Patient/Friend/Attorney): ____

Primary Insurance Company Name: ______________________
Secondary Insurance Company Name: ______________________

Is this a labor and industries claim? ( ) Yes ( ) No
Have you worked with a lawyer as a result of your injury? ( ) Yes ( ) No