Registration Form

University
Physician Group

Date ______________________

Patient Information

Patient Name: ______________________ Date of Birth: __________ SSN:. __________

Address: ____

City: ______________________ State: __________ Zip Code: __________

Home Phone: ______________________ Daytime Phone: ______________________

Cell Phone: ______________________ E-mail Address: ______________________

Sex: F M Marital Status: Single Married Divorced Widowed

Spouse's Name: ______________________ Spouse's Date of Birth: __________

Primary Care Physician: ______________________ Phone Number: __________

Referring Physician: ______________________ Phone Number: __________

Primary Insurance: ______________________ Group # __________ ID# __________

Subscriber Name: ____

SSN of Subscriber: ______________________ Subscriber Date of Birth: __________

Secondary Insurance: ______________________ Group # __________ ID# __________

Subscriber Name: ____

SSN of Subscriber: ______________________ Subscriber Date of Birth: __________

Patient Employer: ______________________ Occupation: __________

Employer's Address: ______________________ Work Phone: __________

Name of person to contact in case of an emergency: ______________________

Emergency contact phone number: ______________________

Do you have an Advance Directive or a formal document indicating who your durable power of attorney is for health care decisions? ❒ Yes ❒ No

If no, would you like the physician to provide you information on advance Health Care Directives? ❒ Yes ❒ No

Pharmacy Information

University
Physician Group

Patient Name ____________________

We are now able to transmit your prescriptions electronically. Please list your pharmacy information below:

Local Pharmacy: ____________________ Phone Number: ____________________

Address: ____________________ City: ____________________
(street address if known or main road with closest cross street)

Mail Order Pharmacy: ____________________ Phone Number: ____________________

Address: ____________________ City: ____________________ State: __________ Zip Code: __________

Patients being seen for an injury

Were you seen in an emergency room for this problem? ❐ Yes ❐ No Hospital: ____________ Date: ________

Hand Dominant: ❐ RIGHT ❐ LEFT ❐ BOTH

__________ Pain onset was ❐ gradual ❐ sudden ❐ no pain

__________ Injury ❐ auto accident ❐ work injury ❐ other accident ____________________

__________ Injury at work Date: __________ From a ❐ lift ❐ twist ❐ fall ❐ bend ❐ pull ❐ reach
Claim number ____________________

__________ Auto Accident Date of Accident: ____________________
Claim number ____________________
Name and number of case worker ____________________

Comments

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How did you hear about our office? ❐ Physician ❐ Family ❐ Friend ❐ Website ❐ Advertisement ❐ Attorney
Other: ____________________

Patient Signature: ____________________ Date: ____________

Print Name(s) of Legal Guardian: ____________________ Phone Number: ____________

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Responsible Party Signature: ____________________ Relationship: ____________
(if patient is minor or has guardian)