Three Rivers Orthopedic Associates-UPMC
PATIENT REGISTRATION FORM

Patient Information

Name: _____ **Birthdate:** _____-_____-_____

SS#: _____ **Age:** _____ **Sex:** Female **Marital Status** Other

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

EMail Address:_____

Home Phone: (_____**)**_____ **Cell/Pager:(**_____**)**_____

Employer:_____**EmployerAddress:**_____

Work Phone: (____**)**_____ _____**EXT**_____ **Occupation**_____ **Full/Part Time**___

Emergency Contact:_____**Relationship:**_____ **Phone:(**____**)**_____**/(**____**)**_____
Home *Work*

Nearest Relative:_____ **Relationship:**_____ **Phone:(**___**)**_____**/(**____**)**_____
Home *Work*

Primary Care Physician: _____ **Phone Number(**____**)**_____**/(**___**)**_____
Office *Fax*

Address _____**How did you hear about us?**_____

Person Responsible for bill (**Self** if **over** age **18,** legal guardian if under age 18)

Name: _____ **Birthdate:** _____-_____-_____

SS#: _____ **Age:** _____ **Sex:** Female **Marital Status** Other

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

Home Phone: (_____**)**_____ **Cell/Pager:(**_____**)**_____

Employer:_____ _____**Occupation:**_____ **Full/Part time** __

Employer Address:_____

Work Phone: (____**)**_____ _____**EXT**_____ **Relationship to Patient**_____

Primary Insurance (Please present card for verification)

Insurance Name:_____ **Copay-PCP: $**_____ **Specialty:$**_____

Insurance ID#:_____ _____ **Group#:**_____ **Effective date:**____-____-_____

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

Subscriber Name:_____**Sex:** Female **Birthdate:** _____-_____-_____

SS#: _____ **Subscribers Address:** _____

Phone:(____**)**_____**/(**____**)**_____ **Employer:**_____**Address**_____
Home *Work*

Relationship to patient:_____

Secondary Insurance (Please present card for verification)

Insurance Name:_____ **Copay-PCP: $**_____ **Specialty:$**_____

Insurance ID#:_____ _____ **Group#:**_____ **Effective date:**____-____-_____

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

Subscriber Name:_____ **Sex:** Female **Birthdate:** _____-_____-_____

SS#: _____ **Subscribers Address:** _____

Phone:(____**)**_____**/(**____**)**_____ **Employer:**_____**Address**_____
Home *Work*

Relationship to patient:_____

Auto/Workers Compensation Claims

Injury Description:_____

Accident Date/Injury Date:_____ **Type of Claim:** Auto

State of Accident (Auto only)_____ **Workers Comp/Auto Claim #:**_____

Insurance Name:_____ **Phone #:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Contact Person/Agent's Name:_____

Responsible Employer (Workers Comp only):_____

Employer Phone #:_____

****** At your appointment time: You must provide the claim number, the carrier's name and address, along with your adjuster's name to process your worker's comp or auto visit correctly.**