URBAN FAMILY PRACTICE

564 Niagara Street
Buffalo, New York
Tel 716-882-0306 Fax 716-884-8096

Date: _____ Physician: _____

PATIENT REGISTRATION

New or Update: _____ Location: _____

PID # _____

PATIENT INFORMATION

Name _____ Social Security #: _____–_____– _____
Last First MI

Date of Birth: _____ Male: ☐ Female: ☐ Single: ☐ Married: ☐ Age: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ By entering my email address, I give The Orthopedic Clinic Association consent to communicate with me via email.

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

EMERGENCY CONTACT (Someone not living with you)

Emergency
Contact Name: _____ Relationship: _____ Phone: (_____) _____

RESPONSIBLE PARTY INFORMATION

Name _____ Social Security #: _____–_____– _____
Last First MI

Date of Birth: _____ Male: ☐ Female: ☐ Single: ☐ Married: ☐ Relationship to Patient: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

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

Employer: _____ Occupation: _____

PRIMARY CARE AND REFERRAL INFORMATION

Primary Care Physician: _____ Phone: (_____) _____

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

How did you hear about us? _____

TURN PAGE OVER

Name: _____

HEALTH INSURANCE INFORMATION

PRIMARY

Insurance: _____ Address _____

ID#: _____ Group: _____

Policy Holder Name: _____

Policy Holder Employer: _____

Policy Holder Date of Birth: _____ Male: ☐ Female: ☐

Relationship to Patient: _____

SECONDARY

Insurance: _____ Address _____

ID#: _____ Group: _____

Policy Holder Name: _____

Policy Holder Employer: _____

Policy Holder Date of Birth: _____ Male: ☐ Female: ☐

Relationship to Patient: _____

WORKER'S COMPENSATION/INDUSTRIAL INSURANCE INFORMATION

Injury Date: _____ Body Part Injured: _____ Right: ☐ or Left: ☐

Employer at Time of Injury: _____ Phone: (_____) _____

Employer
Address: _____ City: _____ State: _____ Zip: _____

Worker's Compensation / Industrial Insurance

Carrier: _____ Phone: (_____) _____

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

Adjuster Name: _____ Phone: (_____) _____ Claim #: _____

Case Manager: _____ Phone: (_____) _____

I present myself or a child for whom I accept responsibility; recognizing the need for care, consent to any and all services as ordered by my physician and agreed to by me. These services include, but are not limited to, laboratory tests, medical or surgical treatment, examination, and other services rendered under specific instructions of my physician.

_____ _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE