1977 Dewar Drive Suite J
Rock Springs, WY 82901
www.aptwy.com

(307) 382-3228 Phone
(307) 382-6886 Fax

520 Wilkes Drive Suite 17
Green River, WY 82935
www.aptwy.com

(307) 875-1788 Phone
(307) 875-8817 Fax

PATIENT REGISTRATION FORM

Patient Name:____________________________Date of Birth:______/_____/_____SS# _____-______-________

Address:__________________________________City:____________________State:_____ Zip: __________

Sex: M or F Marital Status: Single Married Divorced Other Home Phone:(____)_____-__________

Employer:____Work Phone:(____)_____-__________

Student: Y or N School:______________________________________Cell Phone:(_____)_____-__________

Referring Doctor:_______________________________________Spouse Cell Phone:(_____)_____-__________

Onset of Symptoms OR Date of Injury:____/____/________ **Surgery Date**:_____/_____/_______

Is condition related to: Employment Auto Accident Other Accident

****ALL MEDICARE PATIENTS MUST PROVIDE COMPLETE MEDICATION LIST**** **(____)**Initial

Primary Insurance:

Insurance Company: ____ Phone:(____)_____-________

Insurance Address:_________________________City:________________________State:_____Zip: __________

ID#/Claim#:____ Group #: ____________________________

Policy Holder:______________________________Date of Birth:_____/____/____SS#_____-______-________

Sex: M or F Relation to Policy Holder:____________________ Employer: ________________________

Answer if Policy Holder is different from Patient Home Phone:(____)_____-__________

Address:__________________________________City:______________________State:_____Zip: __________

If Auto or Worker's Comp: Adjuster/Caseworker's Name:_________________Phone:(_____)_____-________

Secondary Insurance:

Insurance Company:____Phone:(_____)_____-________

Insurance Address:_________________________City:________________________State:_____Zip: __________

ID#/Claim#:____ Group #: ____________________________

Policy Holder:______________________________Date of Birth:_____/____/____SS# _____-______-________

Sex: M or F Relation to Policy Holder:____________________ Employer: ________________________

Answer if Policy Holder is different from Patient Home Phone:(____)_____-__________

Address:__________________________________City:______________________State:_____Zip: __________

<u>Relative to Contact in Case of Emergency:</u>

Name:________________________Relation to Patient:__________________Phone:(_____)-____-______

Address:________________________City:____________________________State:_______Zip: ______

How were you referred to our office?
By a Doctor: □ By an Attorney: □ By a Patient: □ Other: □

Please print the name of your source:____

<u>Consent to Treatment:</u>
I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination and treatment. I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy.

<u>Financial Responsibility and Assignment of Benefits:</u>
I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered, durable medical equipment (DME) fit, or splints applied. ***If I choose to not pay any outstanding balance, I could be responsible for court costs and attorney's fees, and interest charges of 1.5% monthly or 18% annually on any outstanding balance not paid that is sent to small claims court.*** In the event of collection procedures, attorney fees and court costs are your responsibility. ***I also understand that the delinquency fee with regards to collections will be equal to 50% of the principal amount owed.*** **(_____)**Initial

<u>Cancellation/No Show Policy</u>
I will kindly give as much notice as possible in the event that I need to cancel a scheduled appointment. Any appointment that is not cancelled or rescheduled prior to or within the time allotted for my appointment will be considered a no-show. ***After 3 such instances I understand that I may be formally discharged as a patient and my Doctor or Case Manager will be notified of this action.*** **(_____)**Initial

<u>I certify that I have read this form and understand its contents.</u>

____ ________________________
Patient/Parent/Guardian Signature Date

____ ________________________
Printed Name Relationship to Patient

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Medication List

Patient Name:___________________________________ Date:_________

Please list all medications you are currently taking. Include the dosage and frequency.

Medication	Dosage	Frequency

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____

If you have a list already we can make a copy.