# TUCKAHOE ORTHOPAEDIC ASSOCIATES, LTD.
# PATIENT REGISTRATION FORM

FOR OFFICE USE ONLY
DR. # _____

**PLEASE PRINT**

Patient Name: _____ Sex: ____M ____F
(Last) (First) (MI)

Date of Birth _____ SS# _____ Age _____ E-mail: _____

Marital Status: ____ Single ____ Married ____Divorced ____Separated

Race (choose one ): ____American Indian/Alaskan Native ____Asian/Pacific Islander ____Asian ____Black (non-Hispanic)
____ Black ____ Caucasian ____Hispanic ____More than one race ____Native Hawaiian
____ Other ____ Other Pacific Islander ____White (not Hispanic) ____Declined

Ethnicity: ____ Filipino ____ Hispanic/Latino ____Not Hispanic/Latino ____Unknown ____Declined

Preferred Language: _____

Patient Address: _____
(Street, Apt. #) (City, State) (Zip)

Patient Phone No. (Incl. Area Code): (H) _____ (W) _____ (Cell) _____

Responsible Party (If Other than Patient) _____

Responsible Party Address (If Different from Patient) _____

Responsible Party Phone No. (If Different from Patient): (H) _____ (W) _____

Responsible Party Employer: _____

Date of Injury _____ or Date of Onset of Pain: _____

Specific Body Area(s) Affected: _____ Right ____ Left ____

Family Physician: _____ Referring Physician: _____

Do you want office notes sent to your Family Physician: _____Yes _____No Referring Physician? _____Yes _____ No

## INSURANCE INFORMATION

**PRIMARY INSURANCE**

Name of Insurance Co: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Subscriber's SS# _____ Sex _____ Employer of Subscriber: _____

Patient's Relationship to Subscriber: __ ____ Self _____ Spouse _____ Child _____ Other

Policy Effective Date: _____ Policy # _____ Group # _____

**SECONDARY INSURANCE**

Name of Insurance Co: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Subscriber's SS# _____ Sex _____ Employer of Subscriber: _____

Patient's Relationship to Subscriber: _____ Self _____ Spouse _____ Child _____ Other

Policy Effective Date: _____ Policy # _____ Group # _____