BRAUNLICH
ORTHOPEDICS

Patient Registration

Patient Information: Today's Date:_____

Last Name	First Name	MI	Family Doctor

SSN	Date of Birth	Marital Status

Sex: Female Male

Race: American Indian Asian Black White Other

Ethnicity: Hispanic Not Hispanic

Primary Language Spoken: _____

Street Address	City	State	Zip

Home Phone	Cell Phone	E-mail Address

Employment Information:

Name of Employer	Status FT/PT	Work Phone Number

Street Address	City	State	Zip

Insurance Responsible Party:

Name	Date of Birth

My pharmacy is:

_____

Name Location Phone #

I give my permission for the office staff to leave a message on my answering machine for

_____ Appointment reminders _____ Request for return phone calls

_____ Test results _____ **No answering machine available**

Emergency Contact:
I give my permission for the office staff to release information regarding my care to the following persons in my absence:

Name Relationship Phone

I give my permission for the office staff to contact me at my **place of employment** regarding the following:

____ Appointment times
____ My medical condition
____ Test results
____ Changes in my treatment
____ Need to return call to office
____ Other _____

I give consent to mail to my home or other designated location:
Lab Results
Any other items that will assist in my care.

_____

Patient's Signature Date

_____

Witness Signature Date