OrthoWest, Ltd. • 7255 Old Oak Blvd C405 • Middleburg Heights OH 44130 • (440)816-5380
Michael A. Banks, MD Robert M. Coale, MD Mark L. Lembach, MD Mark A. Panigutti, MD

Chart

Patient Registration Form

Guar ID

Patient Info

First Name_____ MI____
Last Name_____
Home Address _____
City, St Zip _____
Home Phone_____
DOB_____Age____Gender ☐M ☐F
Marital Status ☐S ☐M ☐D ☐W
Social Security No._____
Nickname_____
Emergency Name_____
Relationship to Patient_____
Emergency Phone_____
Email_____
Employment Status_____
Occupation_____
Employer Name_____
Emp Address_____
Emp City, St Zip_____
Work Phone_____

How to Contact You? Circle which are ok
Phone: Cell Home Work Email
Can we leave a voice mail? Yes or No
Anyone to exclude from your information?

Primary Insurance Info

Insurance Name_____
Name of Policy Holder_____
Policy ID/Number_____
Group Number_____
Date of Birth (Policy Holder)_____
SSN of Policy Holder_____
Insurance Phone_____
Ins Address_____
Ins City, St Zip_____
Employer of Policy Holder_____
Referral Needed?_____Copay_____

Secondary Insurance Info

Secondary Ins_____
Name of Policy Holder_____
Policy ID/Number_____
Group Number_____
Date of Birth (Policy Holder)_____
SSN of Policy Holder _____
Insurance Phone_____
Ins Address_____
Ins City, St Zip_____
Employer of Policy Holder_____
Referral Needed?_____Copay_____

Responsible Party/Billing Info

Responsible Party (for Billing)
If not patient, relationship_____
First Name_____MI_____
Last Name_____
Street Address_____
City, St Zip_____
Home Phone of Resp Party_____
DOB of Responsible Party_____
Gender ( ) or circle ☐M ☐F
Marital Status ☐S ☐M ☐W ☐D
Social Security No._____
Employment Status _____
Occupation _____
Employer Name_____
Emp Address_____
Emp City, St Zip _____
Work Phone _____

Industrial/BWC Claim

BWC Claim Number_____
Date of Injury_____
Date Last Worked_____
Date Returned to Work_____
Industrial Insurance (MCO) Name
_____
Contact Name_____
MCO Phone_____
MCO Fax_____
MCO Address_____
MCO City, St Zip_____
Was the Injury Reported? Y N ?
Describe Injury_____
_____
Occupation_____
Employer at time of Injury_____
Emp Address_____
_____
Emp Phone_____
Contact Person_____
Allowed Codes_____
_____

Accident Info

Date of Injury_____
Type of Accident- ☐Auto ☐Home ☐Work ☐Other
Who treated you first?_____
Lawsuit Pending?_____

Your Lifetime Release and Authorization

"I request that payment of authorized insurance benefits be made to **OrthoWest, Ltd.** for any services furnished to me by OrthoWest, Ltd. I understand that if I do not have a necessary referral from my PCP or authorization from my insurance company for these services, I will be held responsible for payment. In addition, I understand that I am responsible for any copayments, deductibles, and any coinsurance that may apply. I authorize any holder of medical information about me to release to my insurance company, and its agents, any information needed to determine these benefits or the benefits payable for related services or to facilitate the delivery of medical services. I hereby give my consent to OrthoWest, Ltd. to use and disclose my protected health information for the purposes of treatment, payment, and operations of my health care and this practice. Our Notice to Privacy Practices is available upon request."

X_____

Signature of Responsible Party Date