SOUTHWEST JOINT REPLACEMENT & SPORTS MEDICINE CENTER
PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient Name (Last) _____ (First) _____ (MI) _____

Preferred Full Name (if different from above) _____

Address _____

City, State, ZIP_____

Home Phone (Landline) _____ Cell _____ Work _____

Date of Birth_____ E-Mail Address_____

Social Security Number_____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed_____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Swahili ☐ Mandarin
☐ Indian: Hindi, Tamil, Gujarati ☐ Vietnamese ☐ Other_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Emergency Contact Name_____ Relationship to Patient_____ ☐ Guardian

Address, City, State, ZIP_____

Emergency Contact Home No._____ Emergency Contact Work No._____ Ext._____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self ☐ **Check here if information is same as patient**

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Home Phone_____ Work #: _____Date of Birth_____

Social Security Number_____ Sex: ☐ Female ☐ Male E-Mail Address_____

Address, City, State, ZIP_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Name_____ Subscriber ID: _____ Group #: _____

Name of Insured_____ Insured's Date of Birth_____ Relationship to Insured_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Name_____ Subscriber ID: _____ Group #: _____

Name of Insured_____ Insured's Date of Birth_____ Relationship to Insured_____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____