CENTER FOR ORTHOPAEDIC SPECIALISTS
PROVIDENCE
www.cos-orthopaedics.com

Reset Form Print Form

REGISTRATION FORM

Today's Date: _____ Referring MD: _____

Patient Name (last, first, middle): _____

Sex: _____ Height:_____Weight:_____

Address: _____

City:_____ State:_____ Zip:_____

SSN#: _____ DOB: _____

Home Phone #: _____ Cell Phone #: _____

Driver's License#: _____ Email address: _____

Occupation: _____ Employment Status: _____

Employer: _____ Work Phone #: _____

Spouse Name: _____ Spouse SSN#: _____

INSURANCE INFORMATION

Subscriber Name: _____ Secondary Insurance (if applicable): _____

Subscriber SSN#: _____ Subscriber Name: _____

Birthdate: _____ Subscriber SSN#: _____

Group # _____ Group # _____

Policy #: _____ Policy #: _____

Co-Payment $: _____ Co-Payment $: _____

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

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

REGISTRATION FORM (CONTINUED)

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relationship to Patient: _____

Phone #: _____ Work Phone #: _____

Other Phone #: _____

MEDICARE PATIENTS

I authorize payment directly to the physician services and benefits for
Accept Assignment services: all other services are responsibility of the patient.

Patient Signature: _____ Date: _____

PRIVATE INSURANCE / SELF PAY PATIENTS

We will be happy to bill your insurance; All services not covered by insurance are the financial responsibility of the patient, however you are responsible for any co-payment or co-insurance at the time of service.

Patient Signature: _____ Date: _____