SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

PATIENT REGISTATION FORM

Account #

Patient Name ______________________ Responsible Party's Name ______________________

Address ______________________ City, State ______________ Zip ________

Home Phone ___________ Business Phone ___________ Cell Phone ___________ Sex ☐ Male ☐ Female

Birth Date ___________ Age ________ Patient's Social Security # ______________

Is this an Injury? ☐ Yes ☐ No Related to? ☐ Auto Accident ☐ Job Related ☐ Other

Explain ____

If Industrial, Reps Name and Phone # ______________________________

Is Patient ☐ Single ☐ Married ☐ Other How were you Referred to Our Office? ______________

Is Patient ☐ Employed ☐ Not Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other

Responsible Party Social Security # ______________ Relationship to Patient ______________

Employer/School Name and Address ______________________ Occupation ______________

Spouse or Nearest Relative Name/Address ______________________________

What are You Being Seen for? ______________________ Date of Injury/Symptoms ______________

Medication Allergies ______________________ Are You Pregnant? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Co. Name ______________	Co. Name ______________
Policy Holder's Name ______________	Policy Holder's Name ______________
Relationship to Patient ______________	Relationship to Patient ______________
Employer ______________	Employer ______________
Policy # ________ Group # ________	Policy # ________ Group # ________
Policy Holder's Sex ☐ Male ☐ Female	Policy Holder's Sex ☐ Male ☐ Female
Policy Holders Date of Birth ______________	Policy Holders Date of Birth ______________

I hereby authorize Seivert Orthopedics & Sports Medicine, P.C. to release any information required from my examination or treatment. I hereby authorize payment directly to Seivert Orthopedics & Sports Medicine, P.C. at 4611 E Shea Blvd. Ste 200, Phoenix, AZ 85028 for all services I have received. I understand I am financially responsible for services not covered by my insurance carrier. I further agree to pay all finance charges, collection costs, attorney fees, and any other cost incurred to enforce my account.

Signed ______________________________ Date ______________