ORTHO SPINE AMERICA

John G. Atwater, MD-PA
Sheree Ewar, ARNP

Patient Registration Form

MRN _____

PATIENT INFORMATION

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address

Gender M F	SSN	Preferred Language	Driver's License

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

Preferred Contact
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal (MyChart)

Ethnicity
- ☐ Cambodian
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Employer

☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other _____

Primary Care Provider	Referring Provider

How did the injury occur? ☐ Auto ☐ Work ☐ Personal ☐ Other _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Patient is Subscriber / Policy Holder Y N	Patient is Subscriber / Policy Holder Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber / Policy Holder	Relationship to Patient
Address	City
SSN	Date of Birth
His or Her Employer	Work Phone Number

RESPONSIBLE PARTY (Guarantor)				
First Name	Last Name		MI	Date of Birth
Address	City		State	Zip
Please check primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐	
SSN	Relationship to Patient	Preferred Language	Driver's License	

EMERGENCY CONTACT (for minor child, this section may be used for other parent)				
First Name	Last Name		MI	Date of Birth
Address	City		State	Zip
Please check primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐	

I/We do hereby consent to and authorize the performance of all treatments, surgeries, and medical services deemed advisable by the physicians and staff of John G. Atwater, MD-PA, Sheree Ewar, ARNP, and affiliated medical groups to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I fully understand this agreement and consent will continue until canceled by me in writing.

Signature _____ Relationship to Patient _____

Printed Name _____

ORTHO SPINE AMERICA

John G. Atwater, MD-PA
Sheree Ewar, ARNP

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