St. George Orthopedic Spine
617 E Riverside Dr Ste 302
St. George, UT 84790
(435) 652-6024 - (435) 652-6025 FAX

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (FIRST -- MIDDLE INITIAL -- LAST)		
PATIENT SOCIAL SECURITY #	**DATE OF BIRTH**	**SEX** ❑ Male ❑ Female
ADDRESS		
CITY, STATE, ZIP		
HOME PHONE #	**WORK PHONE #**	**CELL PHONE #**
PREFERRED PHONE # ❑ Home ❑ Work ❑ Cell	**EMAIL ADDRESS**	

REQUIRED BY NEW FEDERAL REGULATIONS

RACE	**ETHNICITY**	**PREFFERED LANGUAGE**	**MARITAL STATUS** ❑ Single ❑ Married ❑ Other_____

PATIENT EMPLOYER NAME	**PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)**	**EMPLOYER PHONE**
PREFERRED PHARMACY	**PRIMARY DOCTOR**	**REFERRING DOCTOR**

INSURED/RESPONSIBLE PARTY INFORMATION — **RELATION TO PATIENT:** ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)		**ADDRESS (if different from patient)**		
HOME PHONE	**WORK PHONE**	**SSN**	**BIRTH DATE**	**EMPLOYER**

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
ID NUMBER	**GROUP NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**
SECONDARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
ID NUMBER	**GROUP NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**

IN CASE OF EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE NUMBER**

Authorization to release health information to: (EXAMPLE: SPOUSE/PARTNER, PARENT, CHILD)

Name(s)	
PHONE	
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**