CMH Orthopedic Service, LLC – South Hill, VA
A Service of Community Memorial Healthcenter

Patient Registration (PLEASE PRINT CLEARLY)

Patient's Name: _____ **Social Sec. #:** _____

Date of Birth: _____ Primary Phone #: _____ Secondary Phone #: _____
Home Cell Business Home Cell Business

Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Preferred Method of Communication: Home Ph. ☐ Cell Ph. ☐ Work Ph. ☐ / Ethnicity: _____

Mailing Address: _____ City, State: _____ Zip_____

911 Address: _____ City, State: _____ Zip_____

Patient's Employer: _____ Work Phone #: _____

Preferred Pharmacy: _____ City, State: _____

Family Doctor: _____ City, State: _____

Spouse's Name: _____ Social Sec. #: _____

Spouse's Date of Birth (If he/she is the primary insurance holder): _____

Responsible Party: _____ Relationship to Patient: _____

In Case of emergency, contact: _____ Ph. # w/ Area Code: _____

Relationship to Patient: _____

If patient is a Minor, are parents ☐ Married ☐ Divorced - Custodial Parent: _____

Custodial Parent Home Ph. w/Area Code: _____ Work Ph. w/Area Code _____

Custodial Parent SS #: _____ Date of Birth: _____

Is this a work-related visit? ☐ Yes* ☐ No If yes, date of injury? _____ Claim #: _____

*If this is a work related visit you will be required to complete Workers' Compensation/Insurance Form

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MUST PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING

If you do not have insurance, how do you plan to pay for your visit today? ☐ Cash ☐ Credit ☐ Check

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- I hereby authorize the payment of medical benefits to CMH Orthopedic Service, LLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collection costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize CMH Orthopedics to release any medical information necessary to complete and process my insurance claims.

_____ _____

Patient's or Insured's **Signature** (If pt is a Minor, must have Responsible Party Signature) **Date**