



COLUMBUS
ORTHOPEDIC &
SPORTS MEDICINE
CLINIC, P.C.

Account # _____

Date: _____

Richard R. Cimpl, M.D. • Cody S. Harlan, M.D.
4508 38th St, Ste 133 - Columbus, NE 68601

PATIENT REGISTRATION SHEET

Patient Name _____ SEX M F

Patient Address _____ City, State, Zip _____

Home Phone _____ Wk Phone _____ Cell Phone _____

Birth date ____/____/____ SS# _____ Marital Status S M D W Child

Referring Physician _____ Family Physician _____

Patient Employer _____

Parent/Spouse Name _____ Same Address YES NO
(If address is different, please write the address on the back of this sheet.)

Parent/Spouse Birth date ____/____/____

Parent/Spouse Employer _____ Work Phone _____

EMERGENCY CONTACT (RELATIVE, FRIEND, NEIGHBOR)

Name _____ Phone Number _____

Address _____

WORK RELATED INJURIES

IS YOUR INJURY WORK RELATED? YES NO DID YOU REPORT IT? YES NO

EMPLOYER _____

DATE OF INJURY _____

INSURANCE INFORMATION

Please complete the following so we may file your insurance correctly. **WE DO NEED TO HAVE A PHOTOCOPY OF YOUR INSURANCE CARD.**

Primary Insurance _____

Name of Insured _____ **Birth date** ____/____/____ **SS#** _____

Secondary Insurance _____

Name of Insured _____ **Birth date** ____/____/____ **SS#** _____

Services are rendered on a cash basis only unless previous arrangements are made.

I authorize the release of any medical information required to process this claim.

I agree that should my insurance coverage be insufficient to cover the entire amount of the charges, I or my agent will be responsible for and will pay the difference.

“A copy of this is as good as the original.”

Date _____ **Signature** _____