Midwest Sports Medicine Institute
2521 Allen Blvd.
Middleton, WI 53562
(608) 831-3335 fax (608) 829-2731

Registration Form

patient information

last name	first name	M.I.	previous name	home phone ( )

address	city	state	zip code	cell phone ( )

date of birth	social security number	sex [ ] M [ ] F	employer	work phone ( )

marital status [ ] single [ ] married [ ] divorced [ ] separated [ ] widowed	employer address (city, state, zip)

Race [ ] caucasian [ ] African American [ ] native American or Alaskan native [ ] hispanic ethnicity [ ] Asian/Pacific islander [ ] other *please read below	contact in case of emergency	emergency contact phone

- How did you hear about us? -

students

Students, please complete this section:

parent(s) name(s)	home phone ( )

parent(s) home address	city	state	zip code	work phone ( )

responsible for bill

Person responsible for payment of services **Students, only complete this if parents are not responsible for payment**
[ ] check if self

last name	first name	M.I.	home phone ( )	work phone ( )

address	city	state	zip code	relationship to patient

worker's comp

Worker's Comp – Please complete this section

date of injury or onset of symptoms	place of injury	employer at time of injury or onset of symptoms [ ] check if same as above

worker's Comp carrier	case manager	case #

worker's Comp policy #	case manager's phone ( )

insurance information

Primary insurance coverage/Medicare			**Secondary insurance coverage**		
insurance name			insurance name		
insurance street address			insurance street address		
insurance city	insurance state	zip code	insurance city	insurance state	zip code
member/certificate #	group/plan/file #	person #	member/certificate #	group/plan/file #	person #
effective date	expiration date, if any	[ ] personal plan [ ] group plan	effective date	expiration date, if any	[ ] personal plan [ ] group plan
policyholder is: [ ] self [ ] spouse [ ] parent [ ] other			policyholder is: [ ] self [ ] spouse [ ] parent [ ] other		
If policyholder is not self, policyholder's name	policyholder's SSN		If policyholder is not self, policyholder's name	policyholder's SSN	
policyholder's employer	policyholder's date of birth		policyholder's employer	policyholder's date of birth	

signature **date**

* We are required by the State of Wisconsin, Division of Health and Social Services, to collect data regarding **race** and **ethnicity**. The State of Wisconsin uses these data to assess health care provided to minority groups and to develop health programs. The State of Wisconsin determines categories for race and ethnicity.