



ARTHRITIS CARE CENTER, PC

COMPLETE RHEUMATOLOGY CARE

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PATIENT REGISTRATION FORM

NAME _____ (first) _____ (ml) _____ (last) DOB _____ (date of birth)

MAILING ADDRESS _____ (street) _____ (city) _____ (state) _____ (zip code)

HOME PHONE (_____) _____ CELL PHONE (_____) _____

E-MAIL ADDRESS _____ SS# _____ SEX _____

MARITAL STATUS: M S D W SPOUSE SS# _____ - _____ - _____

NAME OF SPOUSE _____

EMERGENCY CONTACT _____ PHONE(_____) _____
(someone who does not live with you – e.g., relative, friend)

PATIENT EMPLOYMENT INFORMATION

PLEASE CIRCLE: RETIRED DISABLED EMPLOYED FULL-TIME PART-TIME

EMPLOYER NAME _____ PHONE(_____) _____

EMPLOYER ADDRESS _____

PATIENT HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____

INSURED NAME _____ DOB _____

INSURED ADDRESS _____ PHONE(____) _____

INSURED EMPLOYER _____ SS# _____ - _____ - _____

EMPLOYER ADDRESS _____ PHONE (____) _____

SECONDARY INSURANCE NAME _____

INSURED NAME _____ DOB _____

INSURED ADDRESS _____ PHONE(____) _____

INSURED EMPLOYER _____ SS# _____ - _____ - _____

EMPLOYER ADDRESS _____ PHONE (____) _____

HEALTHCARE PROVIDER INFORMATION

REFERRING PHYSICIAN _____ PHONE (____) _____
(FIRST) (LAST)

Diagnosis _____

PRIMARY CARE PHYSICIAN _____ PHONE (____) _____
(FIRST) (LAST)

PHYSICIAN ADDRESS _____ PHONE (____) _____

ADDITIONAL PHYSICIANS

PHYSICIAN NAME _____ PHONE (____) _____

PHYSICIAN NAME _____ PHONE (____) _____

PHYSICIAN NAME _____ PHONE (____) _____

Signed

Date