THE KNEE • HIP • SHOULDER CENTER

Thomas V. King, M.D.
Ira M. Parsons M.D.

Date:_____

Last Name: _____ First Name: _____ MI:_____ Suffix: _____

DOB:_____ M:____ F:____ SS:_____ Primary care physician _____

Mailing Address: _____

Physical Address if different then mailing address: _____

City: _____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Email: _____ Enroll in KHS Portal: Yes___ NO___s

Place of Employment: _____

Emergency Contact: _____ Phone:_____ Relationship: _____

Preferred Pharmacy: _____ Phone: _____

Insurance Information

Primary Insurance Plan: _____ ID: _____ GP:_____

Insured name if other than patient: _____

Insured DOB if other than patient: _____

Prior surgery for this problem?_____ By whom: _____ When: _____

How did you hear about our practice: _____

I certify that to the best of my knowledge, the information contained in this Patient Registration is true and complete

*** I consent to treatment by the providers in the Knee Hip Shoulder Center

Patient Signature: _____ Date: _____