ARTHROSCOPY & SPORTS MEDICINE CLINIC

Deborah A. Faryniarz, M.D., Inc.
Sports Medicine and Shoulder Fellowship,
The Hospital for Special Surgery,
FORUM, Society of Fellowship Trained
Women in Orthopaedic Surgery
Grady L. Jeter, M.D., Inc.
Member Arthroscopy Association of North America,
International Society of Arthroscopy,
Knee Surgery and Orthopaedic Sports Medicine,
Founding Member Ikeuchi International Society for Arthroscopy and Musculoskeletal Endoscopy
Martin Trieb, M.D., Inc.
Member Arthroscopy Association of North America

Diplomates American Board of Orthopaedic Surgery • Members American Orthopaedic Society for Sports Medicine
Fellows American Academy of Orthopaedic Surgeons

PATIENT REGISTRATION

Date: _____ Date Of Birth: _____ Referred By: _____

Patient Name: _____ SS#: _____

Sex: Male/ Female Marital Status: S M D W Age: _____

Home Phone: ( ) _____ Cell: ( ) _____

Address: _____ City: _____ State: ___ Zip: _____

Employer: _____ Work Phone: ( ) _____

Employer Address: _____ Occupation: _____

Spouse Name: _____ Employer: _____

Please provide us with valid credit or debit card information to facilitate the settlement of any balances that may be your responsibility after we have settled with your health insurance carrier.

Cancellations and No Show Appointments: Please be courteous and give our office 24 hour advance notice. If you cancel less than 24 hours before your appointment, there will be a $50.00 cancellation charge.

Credit Card:

Cardholder Name: _____
Last First MI

Credit Card Type: Visa _____ MasterCard_____ Debit_____

Card Number # _____ Security# (3 digits) _____

Exp. Date: Month_____ Year_____

Authorized Signature:_____ Date:_____

Witness:_____ Date:_____