

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL PORTIONS

Today's Date: _____

PATIENT

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: _____
Last First Initial

MAILING ADDRESS: _____
Street or Box # Apt. # City State Zip

STREET ADDRESS: _____
Street or Box # Apt. # City State Zip

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____ E-MAIL: _____

SSN #: _____ MARITAL STATUS: Single Married Widowed Divorced Other: _____

OCCUPATION: _____ EMPLOYER: _____ EMPLOYER PHONE: _____

SPOUSE: _____ DOB: _____ EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____ WHO REFERRED YOU? Friend Physician Internet Other

EMERGENCY CONTACT OUTSIDE OF HOME: _____ RELATIONSHIP: _____ PHONE: _____

PRIMARY INSURANCE: _____ ID NO. _____ GROUP NO. _____

SUBSCRIBERS NAME: _____ DOB: _____ SSN: _____

SECONDARY INSURANCE: _____ ID NO. _____ GROUP NO. _____

SUBSCRIBERS NAME: _____ DOB: _____ SSN: _____

ACCIDENT/INJURY INFORMATION

IS THIS AN INJURY? YES NO DATE OF INJURY: _____ BODY PART INJURED: _____ RIGHT LEFT
CAUSED BY: WORK AUTO OTHER HAVE YOU FILED A WORKER'S COMPENSATION CLAIM? YES NO
WORK COMP/AUTO INSURANCE: _____ CLAIM #: _____
CLAIMS ADJUSTER: _____ PHONE#: _____

RESPONSIBLE PARTY (IF PATIENT IS A DEPENDENT OR MINOR) / AUTHORIZATION TO TREAT A MINOR:

NAME: _____ DOB: _____ RELATIONSHIP: _____

RESPONSIBLE PARTY ADDRESS IF DIFFERENT FROM THE PATIENT'S ABOVE: _____ PHONE: _____
Street or Box # Apt. # City State Zip

SOCIAL SECURITY #: _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY AND ATTESTATION OF ACCURACY OF INFORMATION

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional and medical services rendered. I request that payment of authorized insurance and/or Medicare benefits be made to Orthopedic Associates of Northern California. I authorize the release of medical information necessary for the processing of my insurance claim and to the other health care providers for continuity of care. I understand that I am responsible for charges not covered by insurance. I understand I will receive a statement each month if my account has a balance due and a finance charge of 1% per month will be charged on all past due accounts. I have read all of the information on this registration form and have provided the above information. I certify this information is true and correct to the best of my knowledge. I will notify you immediately of any changes in my status or above information.

Patient/Legally Authorized Representative Signature: _____ Date: _____