ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Verified by:

Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			Apt/Unit #:
City:		State:	Zip:
Home Phone #:	Cell Phone #:	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	
E-mail Address:			Driver's License #:
Was this an injury? ☐ Yes ☐ No	If yes, where did your injury occur? ☐ Work ☐ Auto ☐ Home ☐ School		Date of injury:
Employer Name:	Occupation/Title/Position:		
Employer Address and Phone #:			
Emergency Contact Name:	Relationship:	Phone #:	

GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames)

Verified by:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:		State:	Zip:
Home Phone #:		Cell Phone #:	
Employer Name:		Occupation/Title/Position:	
Employer Address and Phone #:			

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

<u>IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS</u>

Verified by:

PRIMARY INS	Insurance Company:	Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:	Group #:	
	Claims Address & Phone #:		
	Insured's Name:	Relationship:	Insured's Date of Birth:
	Insured's Employer:	Insured's Social Security #:	
SECONDARY INS	Insurance Company:	Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:	Group #:	
	Claims Address & Phone #:		
	Insured's Name:	Relationship:	Insured's Date of Birth:
	Insured's Employer:	Insured's Social Security #:	

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits, and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original. **Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a <u>cash patient</u> with payment in full due at the time of service.** This agreement will remain valid from this day forward to include all future services relating to the above patient.

SIGNATURE OF PATIENT/GUARDIAN **DATE**