ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

## Patient Registration

### Patient Information

| First Name | Middle Initial | Last Name |
|---|---|---|
| | | |

| Date of Birth | Social Security Number | Gender |
|---|---|---|
| | | **Male Female** |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Marital Status (circle one) | Primary Care Physician |
|---|---|
| **Married Single Divorced Widowed** | |

| Phone number: Home | Cell | Work |
|---|---|---|
| | | |

verified by:

| Email address | Driver's License # | Employer |
|---|---|---|
| | | |

| Emergency Contact Name | Relationship | Phone |
|---|---|---|
| | | |

| Date of injury/onset of symptoms | Was this an injury? | If yes, Where did your injury occur? |
|---|---|---|
| | **NO YES** | **WORK AUTO HOME SCHOOL OTHER:** |

### Insurance Information

| Name of Primary Insurance: | Name of Secondary Insurance: |
|---|---|
| Insured's Name: | Insured's Name: |
| Insured's Date of Birth: | Insured's Date of Birth: |
| Insured's Social Security number | Insured's Social Security number |
| ID # | ID # |
| Group # | Group # |
| Claims Address: | Claims Address: |
| Phone: | Phone: |

**Guarantor Responsible Party** ☐ **Patient** ☐ **Other (if other please fill in information below)**

verified by:

| Name: | Date of Birth | Relationship to patient: |
|---|---|---|
| | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Phone number | Social Security Number | Employer |
|---|---|---|
| | | |

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 _____