PATIENT REGISTRATION

Please Print Clearly Patient # ________________ Date: ____________________

PATIENT INFORMATION

Patient Name: (Last)_____________________________ (First) ____________________ Middle Initial ______________

☐ Male ☐ Female DOB: ______________ SSN: _______________________ Marital Status: ______________________

Address: _______________________________ City, State, Zip: ___________________________County: ___________

Home Phone: (____)___________ Alt Phone: (____)___________ Referring Doctor: _____________________________

Employment: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Retired/ Retire Date: __________

RESPONSIBLE PARTY

(IF OTHER THAN PATIENT AND/ OR IF PATIENT IS A MINOR, HE/ SHE WILL BE RESPONSIBLE FOR BILL PAYMENT.)

(If address is the same as patient, write SAME)

Name: (Last) ______________________ (First) _______________________ (MI) ________DOB: _________________

Phone: (___)___________________ Address: ____

City, State, Zip: _______________________________________ Relationship to Patient: _________________________

PRIMARY INSURANCE

Carrier Name: _________________________________ ID: _________________________ Group #: _______________

Subscriber Name: (Last) ________________________________ (First) ___________________________ (MI) ________

☐ Male ☐ Female DOB: _____________ SSN: _____________________ Relationship to Patient __________________

Employer: ____ Employer Phone: ____________________________

Employer Address: ____

City: ______________________ State: ______________ Zip: _____________________

SECONDARY INSURANCE

Carrier Name: _________________________________ ID: _________________________ Group #: _______________

Subscriber Name: (Last) ________________________________ (First) ___________________________ (MI) ________

☐ Male ☐ Female DOB: _____________ SSN: _____________________ Relationship to Patient __________________

Employer: ____ Employer Phone: ____________________________

Employer Address: ____

City: ______________________ State: ______________ Zip: _____________________

I assign all insurance payments to OCH Orthopedic clinic. I understand that any unpaid portion of charges for treatment not paid by my insurance company is my responsibility. I understand that if my balance is not paid in a timely manner and the account is referred for outside collections, I am responsible for any processing fees and/or court costs.

Signature: ____ **Date:** ______________________________

EMERGENCY CONTACT (please provide a phone # different from your own)

Name: (Last) ______________________ (First) _______________________ (MI) ________DOB: _________________

Phone: (___)___________________ Address: ____

City, State, Zip: _______________________________________ Relationship to Patient: _________________________

PREFERRED PHARMACY

Pharmacy: _______________________Address: ____________________________ City, State, Zip: _______________