

DOCUMENT NAME: Patient Registration Form  
Director of Health Information Services

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DEPARTMENT & OWNER TITLE: Administration

CURRENT AS OF: November 8, 2022

## Patient Registration Form

Please Print Clearly Patient # \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Information

Patient Name: (Last) \_\_\_\_\_ (First): \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Male  Female DOB: \_\_\_\_\_ Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Ref. Doctor: \_\_\_\_\_

SSN: \_\_\_\_\_ Marital Status: \_\_\_\_\_

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 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: \_\_\_\_\_

DOCUMENT NAME: Job Description Director of Health Information Services	PAGE: 2 OF: 3  <small>Dr. Jordan Ferguson, D.O.</small>
DEPARTMENT & OWNER TITLE: Administration	CURRENT AS OF: November 8, 2022

I assign all insurance payments to OCH Sports Medicine and Orthopedics Center. 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: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Address: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_

NOTE: This is the final page of the OCH Policy/Form. Next page contains revision history only.

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### REVISION HISTORY

Name:	Date:	Page #	Summary of Changes   Revisions
Audra Gines	11.8.22	1	Update logo, formatting, etc.

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