OCH Sports Medicine and Orthopedic Center
Dr. Jordan Ferguson, D.O.

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: _____

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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: _____ _____ _____

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.

REVISION HISTORY

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