

PATIENT REGISTRATION FORM

nsurance 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.	PATI	ENT INFORMATION: (P	lease use full legal	name, n	o nickr	names)						
Address: Salate: Zip:	Last Name:			First Name:				Middle Initial:		ial:	Ver	
Address: Salate: Zip:	Date of Birth:			Age:	: Sex:			Social Security #:			ified I	
Home Phone #: Cell Phone #: Cell Phone #: Marital Status: Married Single Divorced Wildowed	Address:						Apt/Unit #:				oy:	
E-mail Address:	City:					State:		Zip:				
E-mail Address:	Home	Home Phone #: Cell Phone #:			Marital State		/larried	Single	e _	Divorced	Widowed	
Employer Name: Cocupation/Title/Position: Employer Address and Phone #: Relationship: Phone #: GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames) Relationship to Patient: Self Spouse Parent Other Last Name: Middle Initial: Mage: Sex: Social Security #: Address: Zip: Cell Phone #:												
Employer Address and Phone #: Emergency Contact Name:	Was this an injury? Yes No If yes, where did your injury occur? Work Auto Home School Date of injury:										ury:	
### Relationship: Phone #: GUARANTOR INFORMATION: (List person or insured name responsible for bill — use full legal name, no nicknames) Relationship to Patient: self spouse Parent Other	Employer Name: Occupation/Title/Position:											
Relationship to Patient: Self	Employer Address and Phone #:											
Relationship to Patient: Self Spouse Parent Other Last Name: First Name: Middle Initial: Date of Birth: Age: Soc: Social Security #: Age: Soc: Social Security #: Address: City: State: Zip: Home Phone #: Cell Phone #: Employer Name: Occupation/Title/Position: Employer Address and Phone #: Insurance Company: For July 10 #: Claims Address & Phone #: Insured's Smale: Relationship: Insured's Date of Birth: Insured's Date of Birth: Insured's Date of Birth: Insured's Name: Relationship: Insured's	Emergency Contact Name:				Relationship:			Phone #:				
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) ## SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS Policy/ID #: Group #: Claims Address & Phone #: Insured's Name: Relationship: Insured's Date of Birth: Insured's Employer: Insured's Social Security #: Policy/ID #: Group #: Claims Address & Phone #: Insured's Employer: Insured's Social Security #: Policy/ID #: Group #: Claims Address & Phone #: Insured's Date of Birth: Insured's Date o	GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames)											
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City: State: Zip:	Date of Birth:			Age: S		Sex:	: So		Social Security #:			×.
Home Phone #: Employer Name: Docupation/Title/Position:	Address:											
Employer Name: Occupation/Title/Position:	City:				State:			Zip:				
Insurance Company:	Home Phone #:				C	Cell Phone #:						
Insurance Company: Claims Address & Phone #: Insured's Name: Relationship: Insured's Date of Birth: Insurance Company: Copay: HMO PPO POS Policy/ID #: Group #: Claims Address & Phone #: Insured's Social Security #: Insurance Company: Copay: HMO PPO POS Policy/ID #: Group #: Claims Address & Phone #: Insured's Date of Birth: Insured's Name: Relationship: Insured's Date of Birth: Insured's Famployer: Insured's Social Security #: Insured's Semployer: Insured's Date of Birth: Insured's Date of Birth: Insured's Famployer: Insured's Date of Birth: Insured's Date of Birth: Insured's Proposible 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 nsurance carrier. Should identification and insurance cards not be presented at the time of service to enable OSI to submit claims to your nsurance. This agreement will remain valid from this day forward to include all future services relating to the above patient.	Employer Name:					Occupation/Title/Position:						
SOUTH POICE POIC	Employer Address and Phone #:											
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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 cash patient 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.		Insured's Employer:	Ins	Insured's Social Security #:								
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SIGNATURE OF PATIENT/GUARDIAN DATE												