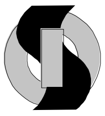

Orthopaedic Specialty Institute

Medical Group of Orange County

Patient Registration

PATIENT INFORMATION (Please Print)

Name: ____________________ **Sex:** ☐ Male ☐ Female

Address: ____________________ **Date of Birth:** ____________ **Age:** ______

____________________ **Social Security #:** ____________________

City, State, Zip: ____________________ **Driver's License/ID #:** ____________________

Race: ____________________ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown / Not Reported

Language: ____________________

Email address: ____________________

Marital Status: ☐ Married ☐ Single ☐ Divorced

Primary Phone: ____________________ ☐ Home ☐ Work ☐ Cell ☐ Other: __________

Primary Physician: ____________________ **Employer:** ____________________

Address: ____________________ **Address:** ____________________

Phone: ____________________ **Phone:** ____________________

Date of injury or onset of symptoms: ____________________ **Was this an injury?** ☐ Yes ☐ No

Where did your injury occur? ☐Work ☐ Auto ☐ Home ☐ School ☐ Other: ____________________

Who referred you to us/How did you hear about us? ____________________

GUARANTOR RESPONSIBLE PARTY ☐ Patient ☐ Other: Relationship:

Name: ____________________ **Employer:** ____________________

Address: ____________________ **Phone:** ____________________

____________________ **Social Security #:** ____________________

City, State, Zip: ____________________ **Date of Birth:** ____________________

PRIMARY INSURANCE Insured Party: ☐ Patient ☐ Guarantor ☐ Other:

Insured's Name: ____________________ **Social Security #:** ____________________

Insurance Carrier: ____________________ **Date of Birth:** ____________________

Claims Address: ____________________ **Insured ID/Cert #:** ____________________

City, State, Zip: ____________________ **Group #:** ____________________

Phone: ____________________

SECONDARY INSURANCE Insured Party: ☐ Patient ☐ Guarantor ☐ Other:

Insured's Name: ____________________ **Social Security #:** ____________________

Insurance Carrier: ____________________ **Date of Birth:** ____________________

Claims Address: ____________________ **Insured ID/Cert #:** ____________________

City, State, Zip: ____________________ **Group #:** ____________________

Phone: ____________________

EMERGENCY CONTACT

Name: ____________________ **Address:** ____________________

Relationship: ____________________ **Phone:** ____________________

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 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. *Rev 05/14*

____________________ ____________________

SIGNATURE OF PATIENT/GUARDIAN DATE