Orthopaedic Specialty Institute
Medical Group of Orange County

Patient Registration

Patient Information

First Name	Middle Initial	Last Name

Date of Birth	Social Security Number	Gender
		Male Female

Street Address	City	State	Zip Code

Marital Status (circle one)	Primary Care Physician
Married Single Divorced Widowed	

Phone number : Home	Cell	Work

verified by:

Email address	Driver's License #	Employer

Emergency Contact Name	Relationship	Phone

Date of injury/onset of symptoms	Was this an injury?	If yes, Where did your injury occur?
	NO YES	**WORK AUTO HOME SCHOOL OTHER:**

Insurance Information

Primary Insurance Carrier	**Secondary Insurance Carrier**
Insured's Name:	Insured's Name:
Insured's Date of Birth:	Insured's Date of Birth:
Insured's Social Security number	Insured's Social Security number
ID #	ID #
Group #	Group #
Claims Address:	Claims Address:
Phone:	Phone:

Guarantor Responsible Party ☐ **Patient** ☐ **Other (if other please fill in information below)**

verified by:

Name:	Date of Birth	Relationship to patient:

Street Address	City	State	Zip Code

Phone number	Social Security Number	Employer

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 <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.

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SIGNATURE OF PATIENT/GUARDIAN DATE