Central Coast Orthopedic Medical Group

PATIENT REGISTRATION AND INSURANCE INFORMATION

Please Print

PATIENT INFORMATION

Name	Today's Date	Date of Injury
Mailing Address	Home Phone	
City / State/ Zip	Work Phone	Cell Phone
Birthdate Age Sex	E-mail address	
Referred by	Social Security #	Drivers License #
Name of person accompanying you today	Person to notify in case of an emergency	Phone #

EMPLOYMENT INFORMATION

Employer	Address of employer	Occupation
Date of injury / accident	Is this injury / accident work related?	Yes No
How did it happen?		

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Subscriber Name	Relationship to Patient	Subscriber Name	Relationship to Patient
Social Security #	Date of Birth	Social Security #	Date of Birth
Certificate / member #	Group #	Certificate / member #	Group #
Employer	Phone#	Employer	Phone #

GUARANTOR INFORMATION

Guarantor's Name (if different from patient Information		Home Phone
Address		Work Phone
City / State / Zip		Social Security #
Date of Birth	Employer	Relationship to Patient

PLEASE READ AND SIGN

I authorize Dr. ________________ to examine me today for my orthopedic condition, and if necessary, to prescribe Medication for my treatment. In the event my physician refers me to another provider, I authorize release of my records to that provider for the purpose of coordination of care. I further authorize my physician to release records relating to my treatment to my referring and/or primary care physician, and in the event of a work-related injury, to my employer.

I understand that CCOMG will bill my primary and secondary insurances as a courtesy, and that I am responsible for any co-pay or balances due that remain unpaid by my insurance carrier(s). In the event that a payment by me is dishonored by my bank or credit card vendor, I acknowledge that I will be liable for a $25 service charge for the reprocessing of my balance due. I authorize release to my insurance carrier, employer in the case of a work-related injury), and/or attorney any information necessary to process and pay the charges arising from my treatment.

I authorize my insurance carrier to make direct payment to the above-named physician and Central Coast Orthopedic Medical Group for all services performed.

_________________________________ _________________________

Signature of Patient or Guardian Date