OSG
A tradition of excellence.
ORTHOPAEDIC AND SPORTS MEDICINE CENTER
-Norman, P.C.

# MINOR REGISTRATION FORM

## PATIENT INFORMATION

**Patient's Name:**_____
*First* *Middle* *Last*

**DOB:**_____ **Age:**_____ **Sex: Male Female** **SS#:**_____
*Month/Day/Year* *(Circle One)*

## PARENT/GUARDIAN OR SPOUSE RESPONSIBLE FOR BILL

**Name:**_____ **SS #:**_____
*First* *Middle* *Last*

**DOB:**_____ **Relationship to Patient:**_____

**Address:**_____
*Street (If P.O. Box, please also list street number)* *Apt.* *City* *State* *Zip*

**Mobile Phone:** (____)_____ **Home Phone:** (____)_____

**Employed By:**_____ **Work Phone:** (____)_____

## INSURANCE INFORMATION

### PRIMARY INSURANCE

**Ins. Co. Name:** _____

**Policy Holder:** _____

**SS #:** _____ **DOB:** _____

**Group #:** _____ **Policy #:** _____

### SECONDARY INSURANCE

**Ins. Co. Name:** _____

**Policy Holder:** _____

**SS #:** _____ **DOB:** _____

**Group #:** _____ **Policy #:** _____

We need your authorization in order to file insurance, speak with or release written information to anyone about your condition. If there is anyone (such as spouse, parent, attorney, etc.) that will be calling on your behalf for any reason, please list them below.

_____

**Name(s) of person(s) and/or insurance company(ies) authorized for release of information**

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also know as Acquired Immune Deficiency Syndrome or AIDS. I further authorize the insurance company listed above to make payment directly to Orthopaedic Sports Medicine Center-Norman, P.C. for services regarding this illness or injury. I understand that I am financially responsible for payment of all charges. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a company of this medical practice's Notice of Privacy Practices.

I further acknowledge that I will be offered a copy of an amended Notice of Privacy Practices at each appointment.

Requested Restrictions_____

**Parent/Guardian Signature:**_____ **Date:** _____

**Print Name:**_____ **Relationship to Patient:**_____