



PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____ **Sex:** Male Female
First Middle Last

DOB: _____ **Age:** _____ **SS#:** _____ - _____ - _____ **Cell Phone #:** (____) _____
Month/Day/Year

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

Employer: _____ **Alternate Phone #:** (____) _____

Primary Care Doctor: _____ **Doctor/Facility who referred you to OSC:** _____

PARENT/GUARDIAN OR PERSON RESPONSIBLE FOR BILL

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

Relationship to Patient: ___ Parent ___ Legal Guardian (please submit documentation) ___ Other: _____

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

Employer: _____ **Work Phone:** (____) _____

IN CASE OF EMERGENCY

Emergency contact person outside your home: _____

Relationship to Patient: _____ **Phone:** (____) _____

Address _____
Street City State Zip

INSURANCE INFORMATION

<u>PRIMARY INSURANCE</u>	<u>SECONDARY INSURANCE</u>
Ins. Co. Name: _____	Ins. Co. Name: _____
Policy Holder: _____	Policy Holder: _____
SS #: _____ DOB: _____	SS #: _____ DOB: _____
Group #: _____ Policy #: _____	Group #: _____ Policy #: _____

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 known 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 copy 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 _____

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

Patient's Signature (or parent/guardian if minor): _____ **Date:** _____