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

PRIMARY INSURANCE	**SECONDARY INSURANCE**
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 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______________________________

Print Name: ______________________________ **Relationship to Patient:** ______________

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

Effective 11/17/2016
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