THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI

OFFICE USE ONLY: DOCTOR#: ________ NEW PT. ______ EST. PT. ________ UPDATE: ____________

PATIENT REGISTRATION FORM

(PLEASE PRINT)

MALE ________ FEMALE ________ MARTIAL STATUS: S M D W

PATIENT'S LAST NAME: ____________ FIRST ____________ MI ____________

ADDRESS ____________ APT# ______ CITY ____________ STATE ______ ZIP ____________

HOME# ____________ WK# ____________ CELL# ____________

DOB: ____________ SS# ____________ EMAIL: ____________

ETHNICITY: ____________ RACE: ____________ PREFERRED LANGUAGE: ____________

MAILING ADDRESS IF DIFFERENT FROM ABOVE: ____________

EMPLOYER NAME: ____________ ADDRESS: ____________

SPOUSE NAME: ____________ WK# ____________ CELL# ____________

FAMILY PHYSICIAN'S NAME: ____________ PHONE# ____________

EMERGENCY CONTACT NAME ____________ PHONE# ____________

WHO REFERRED YOU TO THIS OFFICE? ____________

WORK RELATED? ____________ LIABILITY INJURY? ____________ ATTORNEY INVOLVED? ____________

IF REFERRED BY A PHYSICIAN, HAS HE OR SHE EVALUATED OR TREATED YOU FOR THIS INJURY AND OR SYMPTOM? ____________

IF YES, PHYSICIAN'S NAME: ____________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ *REQUIRED IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)* ~~~~~~

MOTHER'S NAME: ____________ FATHER'S NAME: ____________

DATE OF BIRTH: ____________ DATE OF BIRTH: ____________

SS# ____________ SS# ____________

ADDDRESS ____________ ADDRESS ____________

CITY ____________ STATE/ZIP ____________ CITY ____________ STATE/ZIP ____________

HOME# ____________ WORK# ____________ HOME# ____________ WORK# ____________

EMPLOYER ____________ EMPLOYER ____________

PRIMARY INSURANCE: ____________ INSURED'S NAME ____________

ID# ____________ GROUP# ____________ INSURED'S EMPLOYER ____________

DOB: ____________ SS# ____________ RELATIONSHIP TO PATIENT ____________

SECONDARY INSURANCE: ____________ INSURED'S NAME ____________

ID# ____________ GROUP# ____________ INSURED'S EMPLOYER ____________

DOB: ____________ SS# ____________ RELATIONSHIP TO PATIENT ____________

I hereby authorize payments by my medical insurance plan, be made payable to the physician(s) at THE ORTHOPAEDIC CENTER OF CORPUS CHRIST This authorization is indefinite for any and all treatment I receive. I understand that this authorization does not release me from the responsibility of payment, for all charges not covered by my insurance. It is my responsibility to know what my medical benefits are in regards to my deductible, copay and out of pocket expenses. Copays and deductibles will be collected at the time services are rendered. Payment of self pay patients is expected at the time services are rendered.

SIGNATURE OF PATIENT ____________ *DATE* ____________
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~