Orange County Senior Care

# PATIENT REGISTRATION FORM

(Please Print)

| | | |
|---|---|---|
| Today's Date: | | Insurance Card Copied ❑ YES ❑ NO |

**PATIENT INFORMATION**

| | | |
|---|---|---|
| Patient's Last Name: First: Middle: | ❑ Mr. ❑ Miss<br>❑ Mrs. ❑ Ms.<br>❑ Dr. | Marital Status<br>❑ Single ❑ Married<br>❑ Widow ❑ Divorced<br>❑ Separated |

| | | | | | |
|---|---|---|---|---|---|
| Is this your legal name?<br>❑ Yes ❑ No | If not, what is your legal name? | Driver's License no.: | Birth Date:<br>/ / | Age: | Sex:<br>❑ M ❑ F |

| | | |
|---|---|---|
| Street Address: | Social Security no.: | Home Phone no.:<br>( ) |

| | | | |
|---|---|---|---|
| Cell Phone no.: | City: | State: | ZIP Code: |

| | | |
|---|---|---|
| Employer: | Employer Street Address: | Employer Phone no.:<br>( ) |

| | | |
|---|---|---|
| City: | State: | ZIP Code: |

| | | |
|---|---|---|
| E-Mail Address: | | Check if you prefer NOT to give e-mail address ❑ |

How did you hear about us: ❑ Family ❑ Friend ❑ Close to home/work ❑ Insurance Company ❑ Other_____

| | | | |
|---|---|---|---|
| ❑ Dr. | MD Name (referring): | ❑ Hospital | Hospital Name: |

Primary Language Spoken (Required by the California Department of Health Services): ❑ English ❑ Spanish ❑ Chinese ❑ Other _____

Race (please check one): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Unknown/Not Reported

Ethnicity (please check one): ❑ Hispanic or Latino or ❑ Not Hispanic or Latino ❑ Unknown/Not Reported

**RESPONSIBLE PARTY**

(Please provide your insurance card(s) to the receptionist.)

| | | | |
|---|---|---|---|
| Person responsible for bill: | Birth Date:<br>/ / | Address (if different): | Home Phone no.:<br>( ) |

| | |
|---|---|
| Is this person a patient here? ❑ Yes ❑ No | Driver's License no.: |
| Name of physician: | |

| | | | |
|---|---|---|---|
| Occupation: | Employer: | Employer Street Address: | Employer Phone no.:<br>( ) |

| | | | |
|---|---|---|---|
| Social Security no.: | City: | State: | ZIP Code: |

| INSURANCE INFORMATION | | | | | | |
|---|---|---|---|---|---|---|
| Is this patient covered by insurance? | ❑ Yes ❑ No | | | | | |
| Name of primary insurance: | | | | | | |
| Subscriber's Name: | Subscriber's S.S. no.: | | Birth Date: / / | Group no.: | Policy no.: | Co-payment: $ |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | | |
| Name of secondary insurance (if applicable): | | | | | | |
| Subscriber's Name: | Subscriber's S.S. no.: | | Birth Date: / / | Group no.: | Policy no.: | Co-payment: $ |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | | |

| IN CASE OF EMERGENCY | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home Phone no.: ( ) | Work Phone no.: ( ) |

**ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT**

I/We do hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of Premier Physicians Medical Group which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand I am directly responsible for all charges incurred for medical service for myself and my dependants regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract.

I furthermore agree to pay legal interest, collection expenses, and attorney fees incurred to collect an amount I may owe. I also hereby authorize Premier Physicians Medical Group to release information requested by the insurance company and/or its representative.

_____ I fully understand this agreement and consent will continue until cancelled by me in writing.
*(Initial)*

_____ I authorize Premier Physicians Medical Group to render necessary medical or surgical treatment to the above named minor of whom I am the parent or legal guardian.
*(Initial)*

*Patient/Guardian Signature* *Date*

*Print Name* *Relationship*