PATIENT'S REGISTRATION

Verified By: ______________________

Date: ______________________

If this is a Worker's Compensation claim, please see front desk for additional paper work.

Please answer each item. If an item does not pertain to you, indicate so with a check (   ).

PLEASE PRINT

PATIENT

PATIENT'S LAST NAME | FIRST NAME | MIDDLE NAME | NICKNAME | MAIDEN / PREVIOUS NAME

ADDRESS | CITY | STATE | ZIP

AGE | DATE OF BIRTH | SEX Male Female | SOCIAL SECURITY NUMBER | MARITAL STATUS Widowed Married Divorced Single Separated | HOME PHONE

EMPLOYER'S NAME | OCCUPATION | CELL PHONE

EMPLOYER'S ADDRESS | CITY | STATE | ZIP | BUSINESS PHONE

SPOUSE'S LAST NAME | FIRST NAME | SPOUSE'S SOCIAL SECURITY NUMBER

SPOUSE'S EMPLOYER | BUSINESS PHONE

HOW WERE YOU REFERRED TO THIS OFFICE? | WHO IS YOUR PRIMARY CARE PHYSICIAN?

REFERRING OR PRIMARY CARE PHYSICIAN'S ADDRESS | CITY | STATE | ZIP | PHONE NUMBER

EMERGENCY CONTACT ***(OTHER THAN SPOUSE)*** | ADDRESS | CITY | STATE | ZIP | HOME PHONE

RESPONSIBLE PARTY

RESPONSIBLE PARTY'S LAST NAME | FIRST NAME | MIDDLE INITIAL | RELATION | HOME PHONE

ADDRESS | CITY | STATE | ZIP | SOCIAL SECURITY NUMBER

EMPLOYER'S NAME | OCCUPATION | BUSINESS PHONE

EMPLOYER'S ADDRESS | CITY | STATE | ZIP

INSURANCE

PRIMARY INSURANCE COMPANY NAME | POLICY NUMBER | GROUP NUMBER

POLICYHOLDER'S NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH | EMPLOYER NAME

CLAIMS ADDRESS

SECONDARY INSURANCE COMPANY NAME | POLICY NUMBER | GROUP NUMBER

POLICYHOLDER'S NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH | EMPLOYER NAME

CLAIMS ADDRESS

TERTIARY INSURANCE COMPANY NAME | POLICY NUMBER | GROUP NUMBER

POLICYHOLDER'S NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH | EMPLOYER NAME

CLAIMS ADDRESS

WELFARE NAME (FROM CARD) | WELFARE NUMBER | PERSON CODE | STATE | CARD GOOD ONLY FOR MONTH OF

RESPONSIBILITY & RELEASE OF INFORMATION: I authorize payment of medical benefits for services rendered to U.S.O. I understand that I am responsible to pay all medical services not covered by an authorization / agreement between my physician and insurance company employer. I authorize the release of all or part of the patient medical record for this period of care to any person or corporation liable for any part of the Physician charges. Oklahoma state law (63 O.S. 1-502.2 and 1-502.3) requires that we advise: "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)."

A PHOTOCOPY OF THE AUTHORIZATION AND ASSIGNMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

PATIENT OR AUTHORIZED SIGNATURE | RELATIONSHIP | DATE

DO NOT WRITE BELOW THIS LINE

ACCOUNT NUMBER | TREATING PHYSICIAN | CHART NUMBER