MINOR PATIENT REGISTRATION

DATE: ___________________

Patient's Last Name	First Name	Middle Name	Preferred Name
Address	City	State ZIP	Email

Date of Birth	Sex Male Female	Home Phone	Social Security #
Who was the Referring Physician or PCP?		PCP Phone #	What Pharmacy do you use? (Name & Location)

Responsible Party's Last Name	First Name	Relationship to Patient	Date of Birth	Social Security #
Address	City	State Zip	Primary Phone	

Other Parent's Last Name	First Name	Home Phone
Address	City State Zip	Cell Phone

Emergency Contact (Not Parent)	Relationship to Patient	Home Phone
Address City	State Zip	Cell Phone

Primary Insurance Co Name	Policy Number	Group Number	
Insured's Name	Insured's Social Security #	Insured's Date of Birth	Insured's Employer
Claims Address			

Secondary Insurance Co Name	Policy Number	Group Number	
Insured's Name	Insured's Social Security #	Insured's Date of Birth	Insured's Employer
Claims Address			

RESPONSIBILITY & RELEASE OF INFORMATION: I authorize payment of medical benefits for services rendered to USO. I understand that I am responsible to pay all medical services no 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 1-202.3) 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 Deficient 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	By:

Rev 06/2018