MINOR PATIENT REGISTRATION

DATE: _____

Patient's Last Name	First Name	Middle Name	Preferred Name
Address	City	State	ZIP
Social Security Number	Home Phone		Cell Phone
Date of Birth	Birth Gender: Male ☐ Female ☐	Gender Identity: Identifies as male ☐ Identifies as female ☐ Female to male ☐ Male to female ☐	
Who is your primary care physician (PCP)?		Were you referred to by a physician other than your PCP, if so who?	
What Pharmacy do you use? (Name, Location, and Phone Number)			

Responsible Party's Last Name	First Name	Relationship to Patient	Date of Birth	Social Security #
Address	City	State	Zip	Primary Phone Number
Responsible Party's Email Address		Can we send you information on our Patient Portal? YES ☐ NO ☐		

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
Primary Subscribers: Name	Social Security #	Date of Birth	Employer	Relationship to Patient
Claims Address				

Secondary Insurance Co Name	Policy Number	Group Number
Primary Subscribers: Name	Social Security #	Date of Birth	Employer	Relationship to Patient
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.

AUTHORIZED SIGNATURE	RELATIONSHIP TO MINOR	DATE

DO NOT WRITE BELOW THIS LINE

ACCOUNT NUMBER	TREATING PHYSICIAN

REV 01/21