PATIENT REGISTRATION

DATE: _____

Patient's Last Name	First Name	Middle Name	Preferred Name	Maiden/Previous Name

Address	City	State	Zip

Date of Birth	Birth Gender: Male ☐ Female ☐	Gender Identity: Identifies as male ☐ Identifies as female ☐ Female to male ☐ Male to female ☐	Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Social Security #	Home Phone	Cell Phone

E-Mail Address	Can we send you information on our Patient Portal? YES ☐ NO ☐

Employer's Name	Occupation	Business Phone

Employer's Address	City	State	Zip

Spouse's Last Name	First Name	Phone

Emergency Contact Name (other than spouse)	Phone Number	Relationship

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, Phone Number, and Location)

Are you living in a skilled nursing home? If so, please list the name and contact phone number of the nursing home.

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

Tertiary 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 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 1-202.3) 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 PROVIDER

REV 01/21