SAN MATEO ORTHOPEDIC MEDICAL GROUP PATIENT REGISTRATION FORM

_____ _____ Sex: M/F Marital Status: M W D S

Patient's Last Name First Name

Date of Birth: _____ Social Security No: _____ Driver's License # _____

Address _____

(Street) (City/State/Zip)

Home Phone: _____Cell Phone: _____ Cell Phone Carrier _____

Method of Preferred Communication _____ Work Phone: _____

Email_____ □ Opt Out Patient Portal

Referring Doctors Name_____ Primary Care Doctors Name_____

Occupation: _____ Employer: Name/Address _____

Medical information can be discussed with: □ Patient only or □ Family member or friend: _____

Can detailed messages regarding medical results be left on answering machine/voicemail? _____ Yes _____ No

Race circle one White * Hispanic or Latino * Black or African American * Asian * other *decline / Ethnicity circle one Not Hispanic or Latino Hispanic other

How did you hear about our Practice? _____

Who to call for an emergency: Name: _____ Phone # _____

ACCIDENT: HOME WORK AUTO OTHER PHARMACY NAME AND ADDRESS:

INSURANCE INFORMATION: PLEASE GIVE INSURANCE INFORMATION TO THE RECEPTIONIST. In order to bill your insurance company on your behalf, we must have a current copy of your insurance card on file; it will be copied and kept on file. Note: You will be asked at every visit of any changes to the information on this form. It is in your best interest that we ask you to keep this information current.

Primary Insurance:

Plan Name	Name of Subscriber	DOB	SSN #	Relationship

Secondary Insurance:

Plan Name	Name of Subscriber	DOB	SSN #	Relationship

BENEFIT ASSIGNMENT & ACKNOWLEDGEMNT OF FINANCIAL RESPONSIBILITY:
I authorize the insurance companies to make payment directly to San Mateo Orthopedic Medical Group for medical services. I understand that I am financially responsible for payment of all non-covered services, co-pays, deductibles, and any other charges my insurance company deems my responsibility, In the event my account should become delinquent for a period of thirty days or more I hereby acknowledge that I will be responsible for the entire balance**. *Also, I am aware I am required to cancel or reschedule an appointment with 24 hours notice, otherwise I will be charges a $30.00 fee. Procedures must be cancelled or rescheduled with a 72-hour notice, otherwise I will be charged $75.00***

Signature Date

RELEASE OF MEDICAL RECORDS:
I hereby authorize the release of information, verbal and written, contained in my medical record to my insurance company and related healthcare providers as it relates to my treatment. In addition, I herby authorize this medical office to obtain medical records and/or professional information from any other medical professional as it relates to my treatment

Signature Relationship to Patient Date

DISCLOSURE NOTICES: I acknowledge I have read a copy of the DISCLOSURE NOTICE. I have received a copy of this office's Notice of Privacy Practice: Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California. 800 633-2322(ww.mbc.gov)

Signature Relationship to Patient Date