



PERSONAL

**Legal Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
LAST FIRST MI

**Address** \_\_\_\_\_ **Phone** (\_\_\_\_) \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Cell** (\_\_\_\_) \_\_\_\_\_

**Email address** \_\_\_\_\_

**Birthdate** \_\_\_\_\_ **Family Physician** \_\_\_\_\_ **Referring Physician** \_\_\_\_\_

**Sex** M F (circle one) **Name of Referring Source** (friend, relative, ad, etc.) \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **Marital Status** \_\_\_\_\_

**Driver's License** \_\_\_\_\_ **Any Previous Name** \_\_\_\_\_

**Employer Name** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Employer Address** \_\_\_\_\_ **Work Phone** (\_\_\_\_) \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Message** (\_\_\_\_) \_\_\_\_\_

**Name of Person Not Living With You** \_\_\_\_\_ **Phone** (\_\_\_\_) \_\_\_\_\_

FINANCIAL

**Person Responsible for Payment**  Self \_\_\_\_\_

**Address** \_\_\_\_\_  
CITY STATE ZIP RELATION TO PATIENT

**Home Phone** (\_\_\_\_) \_\_\_\_\_ **Work Phone** (\_\_\_\_) \_\_\_\_\_

**1st Insurance Co.** \_\_\_\_\_ **Name of Insured** \_\_\_\_\_

**SSN of Insured** \_\_\_\_\_ **Birthdate of Insured** \_\_\_\_\_

**Address** \_\_\_\_\_  
CITY STATE ZIP

**Employer** \_\_\_\_\_ **Ins. ID#** \_\_\_\_\_ **Group #** \_\_\_\_\_

**2nd Insurance Co.** \_\_\_\_\_ **Name of Insured** \_\_\_\_\_

**SSN of Insured** \_\_\_\_\_ **Birthdate of Insured** \_\_\_\_\_

**Address** \_\_\_\_\_  
CITY STATE ZIP

**Employer** \_\_\_\_\_ **Ins. ID#** \_\_\_\_\_ **Group #** \_\_\_\_\_

I hereby authorize and consent to examination and treatment as deemed necessary by physicians of Orthopaedic Specialists of North County, A Medical Group, Inc. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by Orthopaedic Specialists of North County, A Medical Group, Inc. in the event of account delinquency, all amounts due including, but not limited to, reasonable attorney's fees.

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Orthopaedic Specialists of North County, A Medical Group, Inc.. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release of all information necessary to secure payment.

I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party and any insurance company, reimbursing agency, third party payer or because of pending legal claims.

Date \_\_\_\_\_ Responsible Party \_\_\_\_\_