Oceanside Office
3905 Waring Road
Oceanside, CA 92056

Carlsbad Office
6121 Paseo Del Norte, Ste 200
Carlsbad, CA 92011

760-724-9000 / Fax: 760-724-3686 / www.orthonorthcountry.com

PATIENT INFORMATION

PERSONAL

Name as presented on insurance card					**Date**		
	LAST	FIRST	MI				
Address				**Phone**			
City		**State**		**Zip**		**Cell**	
Email address		**Family Physician**					
Birthdate		**Referring Physician**					
Sex		**Name of Referring Source** (friend, relative, ad, etc.)					
Race (please circle) American Indian Asian African American Native Hawaiian Caucasian							
Ethnicity (please circle) Hispanic Non-Hispanic				**Preferred Language:**			
Social Security Number	SSN			**Marital Status**			
Driver's License/ID		**State:**		**Any Previous Name**			
Employer Name		**Occupation**					
Employer Address		**Phone number**					
City		**State**		**Zip**			
Name of Emergency Contact				**Phone**			

FINANCIAL

Person Responsible for Payment ☐ Self			
Address ☐ Same as above			
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#**	
2nd Insurance Co		**Name of Insured**	
SSN of Insured		**Birthdate of Insured**	
Address			
CITY	STATE	ZIP	
Employer		**Ins. ID#**	

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: _____ **Patient/Guardian's Signature** _____