

**Pacific Coast Sports Medicine**

**PATIENT REGISTRATION**

ACCT # \_\_\_\_\_

Name: First \_\_\_\_\_ Last \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Guardian (If pt. < 18): First \_\_\_\_\_ Last \_\_\_\_\_

**Patient (or Guardian):** Driver License # \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Pt. Spouse (or 2<sup>nd</sup> Guardian):** First \_\_\_\_\_ Last \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Physician \_\_\_\_\_

Health Insurance: Co. \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Policy ID # \_\_\_\_\_

Check One: PPO \_\_\_\_\_ HMO \_\_\_\_\_ Medicare \_\_\_\_\_ MediCal \_\_\_\_\_ Work Comp \_\_\_\_\_ Auto \_\_\_\_\_ Lien \_\_\_\_\_

2nd Insurance: Co. \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Policy ID # \_\_\_\_\_

Check One: PPO \_\_\_\_\_ HMO \_\_\_\_\_ Medicare \_\_\_\_\_ MediCal \_\_\_\_\_ Work Comp \_\_\_\_\_ Auto \_\_\_\_\_ Lien \_\_\_\_\_

Patient Responsibility, Assignment of Insurance Benefits, Release of Information, & Notice of Privacy Practices

I understand that I am financially responsible for all charges owed under insurance contracts and fully responsible for non-contracted and non-authorized services. All charges owed are payable at the time services are rendered including insurance deductibles, co-payments, and non-contracted services. I authorize my insurance company to issue payment directly to my medical provider for all medical benefits payable to me for services rendered to me or my dependent. I authorize release of any information necessary to obtain such payment. I agree to pay all costs of collection including attorney's fees. I acknowledge all information on the Notice of Privacy Practices webpage of [www.PacificCoastSportsMedicine.com](http://www.PacificCoastSportsMedicine.com) and I may receive a hard copy upon my request.

Signature \_\_\_\_\_ Date \_\_\_\_\_