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SNIBBE ORTHOPEDICS

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last name: First: Middle:			☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birth date:	Age:	Social Security Number:	Sex: ☐ M ☐ F
Preferred Language:			Race:		Ethnicity:
Street address:			Cell phone: ( )		Home phone: ( )
City:	State:	ZIP Code:	Driver's License:	Email address:	
Occupation:	Employer & Employer Address:				Employer phone: ( )

Who referred you to this office? (Please check one box): ☐ Referred by Doctor - Dr.'s Name:

☐ Family – Name: ☐ Friend - Name: ☐ Internet ☐ Hospital – Name:

How would you like us to contact you for appointment reminder: ☐ Home Phone ☐ Cell Phone

PHARMACY: Name, address, and phone number of pharmacy you would like medications called in to:

INSURANCE INFORMATION

(Please give your insurance card to the front desk.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone: ( )

Is this person a patient here? ☐ Yes ☐ No Is this injury: ☐ Work Related ☐ Auto ☐ Personal Injury

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ Blue Cross	☐ Blue Shield	☐ Aetna	☐ Cigna	☐ HealthNet
☐ SAG	☐ PacifiCare	☐ Medicare	☐ Medicare / Medi-Cal	☐ Other	

Subscriber's name:	Subscriber's S.S. number:	Birth date:	Group number:	Policy number:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group number:	Policy number:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone: ( )	Work phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Beverly Hills Orthopedic Group or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*