

PLEASE PRINT CLEARLY

| PATIENT INFORMATION | | | | PATIENT REGISTRATION # | | | |
|--|---------------|--|---------------|--|----------------|--|--|
| Last Name | | First | Middle | Home Phone () | | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Permanent Address | | Street | City | State | Zip Code | Physician | |
| Age | Date of Birth | | School | Patient SS Number | | Referring Physician | |
| Father's Name | | SS# | Date of birth | Occupation/Employer | | Work Phone () | |
| Mother's Name | | SS# | Date of birth | Occupation/Employer | | Work Phone () | |
| Cell Phone: () | | | Name: | | Email Address: | | |
| PARENT / GUARDIAN CAN BE CALLED AT WORK FOR NON-EMERGENCIES | | | | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | |
| Emergency contact (other than parent) | | | | Rel to Patient | | Phone Number () | |
| Nearest Relative not living with you | | Address | | Rel to Patient | | Phone Number () | |
| Pharmacy Name | | Address | | | | Phone Number | |
| PERSON RESPONSIBLE FOR PAYMENT | | | | | | | |
| Last Name | | First | Middle | Social Security Number | | Relationship to patient | |
| Address | | Street | City | State | Zip Code | Phone Number () | |
| Employed by | | Address | | How long? | | Work Phone () | |
| INSURANCE INFORMATION | | | | | | | |
| First Insurance | | | | Second Insurance | | | |
| Name of Insurance Company | | | | Name of Insurance Company | | | |
| Address of Insurance Company | | | | Address of Insurance Company | | | |
| Policy Holder Subscriber Name | | Relationship to patient | | Policy Holder Subscriber Name | | | |
| Complete number as stated on card | | | | Complete number as stated on card | | | |
| Group No. | | Phone No. | | Group No. | | Phone No. | |
| Note: Any claim of insurance or group agency coverage must be confirmed by an identification card or letter of authorization form the Company or Agency at the time of visit | | | | | | | |
| INJURY RELATED INFORMATION | | | | | | | |
| On Job Injury | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Auto Injury | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Date of accident | | Attorney involved | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Name of Attorney | | Address | | | | Phone () | |
| Brief description of accident | | | | | | | |

By signing below, I am giving my consent for treatment. I am certifying that the patient registration information is accurate and insurance coverage is in effect at the time of treatment and I am responsible for notifying Osler Medical of any change to the above information. I understand that I am responsible for verification with my insurance company that Osler Medical is a contracted provider, if applicable. I authorize Osler Medical to furnish my insurance company(s) with any and all information requested and assign payment directly to Osler Medical all benefits due and payable under the terms of my policy.

I understand that I am financially responsible for all charges not paid by my insurance including deductibles, co-pays, and non-covered services. Statements will be sent reflecting my financial responsibility and final payment of this account is my obligation.

I acknowledge that an \$8.00 service charge may be added to my account for co-pays not paid at the time of service and a \$25.00 service charge for a no-show or a cancellation less than 24 hours prior to the scheduled appointment. A late charge of 1½% per month calculated on outstanding balances over 90 days may be applied.

I have had the opportunity to review Osler Medical's "Notice of Privacy Practices".

SIGNATURE AUTHORIZATION

This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned.

Date: _____ Signature: _____