

CALIFORNIA ORTHOPAEDIC INSTITUTE MEDICAL ASSOCIATES, Inc.

PLEASE PRINT

(OFFICE USE ONLY)	ACCOUNT TYPE	DR. NO.	ACCOUNT NO.	DATE
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NEW PATIENT INFORMATION (PLEASE PRESS FIRMLY)

E-MAIL													
PATIENT'S NAME LAST		FIRST		M	SEX	MARITAL STATUS				DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	
						S	M	W	D	SEP			
STREET ADDRESS PERMANENT				CITY AND STATE				ZIP CODE		HOME PHONE NO.			
RESPONSIBLE PARTY (FAMILY) NAME IF OTHER THAN ABOVE				DRIVER LIC. NO				SOCIAL SECURITY NO.					
STREET ADDRESS				CITY AND STATE				ZIP CODE		HOME PHONE NO.			
EMPLOYER OF PATIENT OR RESPONSIBLE PARTY IF MINOR						OCCUPATION (INDICATE IF A STUDENT)			BUS. PHONE NO.				
SPOUSE NAME			EMPLOYER			OCCUPATION			BUS. PHONE NO.				
IN CASE OF EMERGENCY, NOTIFY:										NAME		HOME PHONE NO.	
REFERRED BY DOCTOR				STREET ADDRESS, CITY, STATE & ZIP CODE						PHONE NO.			

INSURANCE INFORMATION

MEDICARE <input type="checkbox"/>	MEDICARE NUMBER #	MEDI-CAL <input type="checkbox"/>	MEDI-CAL NUMBER #
NAME OF INSURANCE COMPANY (PRIMARY)		SECONDARY/SUPPLEMENTAL INSURANCE COMPANY	
STREET ADDRESS		STREET ADDRESS	
CITY, STATE & ZIP CODE		CITY, STATE & ZIP CODE	
GIVE NAME OF POLICYHOLDER		GIVE NAME OF POLICYHOLDER	
GROUP/POLICY NO.	SUBSCRIBER/I.D. NO.	GROUP/POLICY NO.	SUBSCRIBER/I.D. NO.
ACCIDENT <input type="checkbox"/>	<input type="checkbox"/> AUTO/VEHICLE <input type="checkbox"/> OTHER. EXPLAIN _____		DATE OF INJURY

WORK COMP INFORMATION

WERE YOU INJURED ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF INJURY	INDUSTRIAL CLAIM NUMBER
NAME OF WORKMAN'S COMPENSATION CARRIER		ADDRESS. CITY AND STATE	ZIP CODE
PERSON TO CONTACT	BUS. PHONE NO.	HAVE YOU SEEN A PHYSICIAN FOR THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	

PLEASE SIGN THE FOLLOWING FORM

I hereby authorize California Orthopaedic Institute Medical Associates, Inc., to furnish to my insurance company or to a designated attorney, all information which the insurance company or attorney may request. I hereby assign to the above-referenced physicians all monies to which I am entitled and/or surgical expense relative to the services rendered by either of them. It is understood that any money received from the above-named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible, WHETHER MY INSURANCE COMPANY PAYS OR NOT, for all costs incurred by me. I further agree that in the event of non-payment, I will bear the cost of collection and/or Court cost and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be as valid as the original.

Insured or Guardian Signature

Patient's Signature