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NORTHWEST OKLAHOMA ORTHOPAEDIC CLINIC, P.C.

900 West Cherokee, Enid, OK 73701

PATIENT REGISTRATION
PLEASE PRINT AND COMPLETE ALL INFORMATION

FOR OFFICE USE ONLY
Chart No: _____
Doctor No: _____
Account Type: _____

Appointment Date: _____ **Referred By:_____**

PATIENT INFORMATION

FULL LEGAL NAME _____ _____ _____
Last First MI Age Birth Date

Mailing Address: _____
Street City State Zip Code

Mobile Phone _____ Home Phone _____ Work Phone _____ Ext ____

Patient's SSN: _____ Gender (Circle One) M F Employer _____

Current Marital Status (Circle One) SINGLE MARRIED WIDOWED DIVORCED SEPARATED

EMail Address *(legibility is very important)* _____

Spouse's Name _____ Spouse's Birth Date _____ Spouse's SSN:_____

Spouse's Employer _____ Spouse's Phone_____

PHARMACY *(Must have Name - Address - Phone of your preferred pharmacy)*

Name _____ Address _____ Phone _____

NEAREST RELATIVE OR FRIEND TO NOTIFY IN AN EMERGENCY

Name _____ Relationship _____ Phone _____

IF PATIENT IS A MINOR, PLEASE FILL OUT THE INFORMATION BELOW

Father's Name _____

Address (if different) _____

Phone _____ DOB _____

Employer _____

SSN _____

Mother's Name _____

Address (if different) _____

Phone _____ DOB _____

Employer _____

SSN _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The undersigned hereby authorizes Northwest Oklahoma Orthopaedic Clinic, P.C. (the "CLINIC") to at any time release any insurance company or companies, the Social Security Administration, the Department of Public Welfare, the Health Care Financing Administration, their intermediaries or carriers or any other third party payer's, and all medical information contained in my records at the Clinic, whether from a third party source of the CLINIC, or not (the "information") and as may be necessary for the completion a claims or pursuant to my request on behalf of myself. Also, the undersigned authorizes the CLINIC to release such information to my attorney, upon my written request. I hereby authorize the CLINIC (but understand that the CLINIC is not responsible to do so) to submit the claims to any third party payers on my behalf. In consideration of the services rendered, I also assign to the CLINIC payments from an insurance carrier or any other person or party for medical services rendered to myself or my dependence and agree to pay to CLINIC any such proceeds that I might receive. I understand that I am responsible to pay for any amount not covered by third party payer. A photographic copy of these assignments authorized hereunder shall be as valid as the original. I further agree that I will pay for the costs of reproduction of my medical information submitted by the CLINIC under the terms of this authorization.

SIGNATURE :_____**DATE** _____