Patient Registration

Patient

Patient's Last Name	First Name (Full Legal)	Middle Name	Nickname	Maiden / Previous Name

Address	City	State	Zip	Marital Status
				___ Married ___ Single ___ Separated ___ Widowed ___ Divorced

Age	Date of Birth	Sex	Social Security Number	Home Phone	Cell Phone
		__ Male __ Female		( )	

Employer	Occupation	Patient's E-mail Address

Employer's Address	City	State	Zip	Business Phone

Spouse's Last Name	First Name	Spouse's Social Security No.	Spouse's Cell Phone

Spouse's Employer	Business Phone	Emergency Contact Name	Emergency Contact Phone No.

Who Requested that you see us?	Primary Care Physician	Primary Language
		__ English __ Spanish __ Japanese __ Italian __ French __ Portuguese __ Other

Ethnicity	Race
___ Hispanic or Latino ___ Non Hispanic or Latino	__ White __ Black or African American __ Asain __ Native Hawaiian __ Other Pacific Islander __ American Indian __ Other Race __ Refused

Person Responsible for Bill other than Patient

Responsible Party's Last Name	First Name	Middle Name	Relation	Home Phone

Address	City	State	Zip	Business Phone	Extension

Employer	Occupation	Social Security No.	Cell Phone

Insurance

Primary Insurance Company	Policy Holder's Name (From Card)	Policy No.	Group No.

Policy Holders Social Security No.	Date of Birth	Employer Name	Send Claims To:

Secondary Insurance Company	Policy Holder's Name (From Card)	Policy No.	Group No.

Policy Holders Social Security No.	Date of Birth	Employer Name	Send Claims To:

Is this Worker's Compensation? Auto Accident? or Personal Injury?

___ Yes ___ No

Claim Number	Coverage By	Business Phone	Extension

Address	Adjuster	Fax Number

Please explain in your own words how your injury happened and where

Date of Injury	Date Last Worked	Are you on Light Duty?	Attorney Name	Phone Number

Acknowledgement of Receipt of Privacy Notice

The intent of our office is to make you aware of the possible uses and disclosures of your protected heath information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement of the Notice of Privacy Practices. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected information for treatment, payment, and health care operations when necessary. I acknowledge that I have received a copy of the Notice of health Privacy Practices of Oklahoma Spine & Brain Inst.

____ (Patient Signature & Date)

Responsibility Information:

I understand that I am responsible to pay all medical services not covered by an authorization/ agreement between my physician and my insurance company. ____ (Patient Signature & Date)

Release of Information

I authorize the release of all or part of the patient's medical record, for this period of care to any person or corporation liable for any part of the Physician charges. Oklahoma state law (63 O.S. 1-502.2 and 1-502.3) requires that we advise: **"The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS)."**

Patient or Authorized Signature	Relationship	Witness	Date