OSG
A tradition of excellence.
ORTHOPAEDIC AND SPORTS MEDICINE CENTER
-Norman, P.C.

MINOR REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:_____
First *Middle* *Last*

DOB:_____ **Age:**_____ **Sex: Male Female** **SS#:**_____
Month/Day/Year *(Circle One)*

PARENT/GUARDIAN OR SPOUSE RESPONSIBLE FOR BILL

Name:_____ **SS #:**_____
First *Middle* *Last*

DOB:_____ **Relationship to Patient:**_____

Address:_____
Street (If P.O. Box, please also list street number) *Apt.* *City* *State* *Zip*

Mobile Phone: (____)_____ **Home Phone:** (____)_____

Employed By:_____ **Work Phone:** (____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins. Co. Name: _____

Policy Holder: _____

SS #: _____ **DOB:** _____

Group #: _____ **Policy #:** _____

SECONDARY INSURANCE

Ins. Co. Name: _____

Policy Holder: _____

SS #: _____ **DOB:** _____

Group #: _____ **Policy #:** _____

We need your authorization in order to file insurance, speak with or release written information to anyone about your condition. If there is anyone (such as spouse, parent, attorney, etc.) that will be calling on your behalf for any reason, please list them below.

_____

Name(s) of person(s) and/or insurance company(ies) authorized for release of information

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also know as Acquired Immune Deficiency Syndrome or AIDS. I further authorize the insurance company listed above to make payment directly to Orthopaedic Sports Medicine Center-Norman, P.C. for services regarding this illness or injury. I understand that I am financially responsible for payment of all charges. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a company of this medical practice's Notice of Privacy Practices.

I further acknowledge that I will be offered a copy of an amended Notice of Privacy Practices at each appointment.

Requested Restrictions_____

Parent/Guardian Signature:_____ **Date:** _____

Print Name:_____ **Relationship to Patient:**_____