Registration
PATIENT INFORMATION

Patient: _____
(First) (Middle) (Last) (Drivers Lic. No)

If Minor, Name of Guarantor: _____ Relation to Child: _____

Email Address: _____ Patient Social Security #: _____

Patient Address: _____
(Street Address) (City) (State) (Zip)

Home Phone: _____Work Phone: _____Cell Phone:_____

I authorize Pacific Bone and Joint Clinic to use my cell phone (SMS text and/or voice messaging) for appointment reminders: _____(initial)

Sex: M ___ F ___ Date of Birth: _____

Preferred Language:_____ Ethnicity/Race:_____

Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed Spouse/Domestic Partner:_____

Family Physician: _____Referred by? _____

Major complaint: _____

Date of Injury or Onset of Problem: _____

Occupation of Patient: _____ Employer Name: _____

Employer's Address: _____
(Street Address) (City) (State) (Zip)

Name of Friend/Relative (other than Spouse) in case of emergency: _____

Relationship to Patient: _____ Phone Number: _____

I authorize Pacific Bone and Joint Clinic to release my name and phone number to other patients experiencing similar treatment _____
initial

PATIENT INSURANCE INFORMATION:

Primary: _____ _____ _____ _____
(Name of carrier) (Name of Subscriber) (Birth date) (I.D. Number)

Secondary:_____ _____ _____ _____
(if applicable) (Name of carrier) (Name of Subscriber) (Birth date) (I.D. Number)

I understand that I am financially responsible for all charges whether or not paid by insurance. I, the undersigned, have insurance coverage and assign directly to Christopher J. Chen, MD all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize this office to release all necessary information regard to the above, as well as to pharmacists and physical therapists.

IF YOUR INSURANCE DETERMINES YOU ARE NOT COVERED FOR OUR SERVICES OR MEDICAL SUPPLIES, YOU WILL BE RESPONSIBLE FOR ALL CHARGES.

DATE: _____ SIGNED: _____