

**ORTHOPEDIC MEDICAL GROUP OF SAN DIEGO, INC.**

\_\_\_ Richard D. Coutts, MD (1)  
\_\_\_ Richard F. Santore, MD (2)  
\_\_\_ Carl D. Maguire, MD (3)  
\_\_\_ Michael P. Muldoon, MD (5)  
\_\_\_ William E. Bowman, MD  
\_\_\_ Robert K. Eastlack, MD (6)

7910 Frost Street, Suite 200  
San Diego, CA. 92123  
(858) 278-8300

\_\_\_ Update \_\_\_\_\_  
\_\_\_ New Info \_\_\_\_\_  
\_\_\_ Entered \_\_\_\_\_  
\_\_\_ Verified \_\_\_\_\_

**For Office Use Only**

**REGISTRATION INFORMATION**

( ) PVT ( ) PPO ( ) M-CAL ( ) M-CARE ( ) HMO ( ) TRICARE ( ) POS Date \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) Work Phone: ( )

Mobile: ( ) E-mail: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred By: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Primary M.D.: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Insured Name:** \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: ( ) Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Telephone: ( )

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: ( ) Copay\$: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: ( ) Copay\$: \_\_\_\_\_

**Attorney:** \_\_\_\_\_ Telephone #: ( )

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Friend / Relative in this area: \_\_\_\_\_ Telephone #: ( )

Have you ever been seen in this office before? Yes ( ) No ( ) By: \_\_\_\_\_ When: \_\_\_\_\_

I understand that patients who carry medical insurance should remember that professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments to the doctor. I accept financial responsibility for all charges incurred. I understand that statements are due when presented to me by Orthopedic Medical Group or when transferred to me by my insurance carrier.  
AUTHORIZATION: I hereby authorize payment directly to Orthopedic Medical Group of San Diego, Inc. for medical services by that group, and to release any information acquired in the course of my examination or treatment to my insurance company.

Patient's / Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Patient Name: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured I.D.#: \_\_\_\_\_

1. Was your office visit related to an accident/injury?  
(Please circle one) YES or NO

2. **WHEN** did the accident occur? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

3. If yes, **WHERE** did the accident occur? \_\_\_\_\_

- \_\_\_\_\_ Your Home
- \_\_\_\_\_ Work Related
- \_\_\_\_\_ Auto Accident
- \_\_\_\_\_ Other (Please explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Please describe **HOW** the accident/injury occurred?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THE FOREGOING IS TRUE AND CORRECT TO THE  
BEST OF MY KNOWLEDGE.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_