

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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ELIGIBILITY GUARANTEE

I, _____, hereby certify
NAME OF PATIENT/MEMBER/GUARDIAN

that I am eligible for _____
HEALTHPLAN

effective _____. I have chosen _____
MEDICAL GROUP &/OR

_____ to be my Medical Provider.
PHYSICIAN

I understand that if the above is not true or if I am
not eligible under the terms of my Health Plan
Agreement, I am liable for all charges for services
rendered. Also, if the above is not true, I agree to pay
in full for all services received within 30 days of
receiving a bill from the above noted provider.

SIGNATURE OF MEMBER/GUARDIAN

SUBSCRIBER NUMBER/SOCIAL SECURITY NUMBER

7910 Frost Street, Suite 200
San Diego, CA 92123
(858) 278-8300
Fax: (858)278-1708