



ARTHRITIS, ORTHOPEDIC, AND SPORTS MEDICAL CENTER

1505 Wilson Terrace Suite 200, Glendale California 91206
 Phone (818) 246-8974 Fax (818) 246-7673

- Please complete this form in its entirety. Any sections that do not apply to you please enter N/A (not applicable). Thank you for your assistance in helping our office complete your registration. **Omissions, errors, and/or inability to read this information can result in the inability of our office to contact you as needed and/or delay or failure of insurance carriers to pay for your services here.**

My appointment is with: _____ Dr. Merritt _____ Dr. Orlando

Name: Last, First, and Middle Initial (Please enter NMI if you do not have a middle initial.) WE NEED YOUR LEGAL NAME

Should you wish to use a nickname, please enter this name here? _____

Home Phone Number: Area Code () _____ Cell: () _____ Driver's License: _____
 E-mail address: _____
WE MUST HAVE A STREET ADDRESS
 Street Address _____ Apartment # _____
 City and State _____ Zip Code _____

Marital Status: S M W D SEP Sex: M F Date of birth: _____ Social Security Number: _____

Other than English, list the language(s) understand: When spoken: _____ When Read: _____

PERSON NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY:

Name _____ Relationship _____
 Telephone number: Home () _____ Cell () _____ Work () _____

PATIENT'S EMPLOYER: (*If a minor, please list father's employer in this section.)

*Father's date of birth, if patient is a minor _____ (*required by insurance carrier)
 Employer: _____ Occupation _____
 Telephone number: () _____

SPOUSE'S INFORMATION: (*If a minor, please list mother's information in this section.)

*Mother's date of birth, if patient is a minor _____ (*required by insurance carrier)
 Name of Spouse: _____ Telephone Number: () _____
 Employer: _____ Occupation _____
 Telephone number: () _____

If you have more than one insurance, please list the primary carrier first.
 Please list name of insured person if other than the patient. CO-PAY AMOUNT \$ _____

Primary Insurance _____ Insured Person _____
 Secondary Insurance _____ Insured Person _____
 Third Insurance _____ Insured Person _____

CARRIERS REQUIRE WE SEND COPIES OF YOUR INSURANCE CARD. PLEASE FURNISH US WITH YOUR INSURANCE CARD(S) FOR PHOTOCOPYING.
ALL CO-PAYMENTS ARE PAID AT THE TIME OF SERVICE PER YOUR INSURANCE CONTRACT.

REASON FOR VISIT: _____ Second Surgical Opinion _____ Illness _____ Gradual Onset _____ Injury
 (If an injury, please circle one) Auto Accident [Driver / Passenger] / Work / Home Other: _____

Date of Injury or onset: _____ (month / day / year)

Comment: _____

PLEASE TURN PAGE OVER

If you are being seen as the result of an injury and you are seeking payment of medical bills from a third party, please indicate the responsible person's name here and the billing information.

For third party liability cases, please complete this section:

Name of person liable for payment of medical bills _____

Name and address of insurance covering this injury _____

Policy/Claim Number _____ Telephone number (____) _____

Adjuster/Person handling your case _____

If you have an attorney assisting you with your injury claim, please list their name, address and phone number:

Attorney: _____ Address: _____ Phone Number: _____
(____)

THIS OFFICE DOES NOT ACCEPT LIENS AS PAYMENT FOR SERVICES RENDERED.

How were you referred to us? Please circle the appropriate referral source and indicate name, address and phone number.

Referring Physician	Employer	School	Television
Friend/Relative/Former Patient	Hospital	Seminar/Screening	Radio
HMO/PPO	Case Manager	Yellow Pages	Newspaper
Advertisement where did you see/hear this advertisement?	_____	Other	

Name: _____ Address: _____ Phone Number: _____
(____)

May we contact this person to thank them for the referral? Yes No

TO MEDICARE PATIENTS: MEDICARE DOES REQUIRE WE ENTER THE NAME OF THE REFERRING PHYSICIAN ON YOUR CLAIM FORM. WITHOUT THIS INFORMATION, THE CLAIM CANNOT BE PROCESSED.

TO COORDINATE YOUR MEDICAL CARE, PLEASE LIST THE NAME AND TELEPHONE NUMBER OF YOUR FAMILY PHYSICIAN AND/OR CURRENT TREATING PHYSICIAN.

Name: _____ Telephone Number: (____) _____

I hereby authorize Arthritis, Orthopedic, and Sports Medical Center to release any and all medical information to the above-named insurance carrier or to designated attorney for the purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Arthritis, Orthopedic, and Sports Medical Center all money to which I am entitled for medical and/or surgical expenses relative to the service rendered by Arthritis, Orthopedic, and Sports Medical Center, but not to exceed my indebtedness to Arthritis, Orthopedic, and Sports Medical Center. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to me or the insurance carrier when my bill is paid in full. I understand I am financially responsible to Arthritis, Orthopedic, and Sports Medical Center for charges not covered by this assignment. I further agree in the event of nonpayment to bear the cost of collection and/or Court cost and reasonable legal fees should this be required.

This is an authorization for medical treatment of a minor, if signed by a guardian or parent.

Parent or Guardian's Signature (if patient is under the age of 18 years of age) _____
Patient's Signature _____ Date _____

We wish to thank you for allowing Arthritis, Orthopedic, and Sports Medical Center to assist you with your medical care and thank you for your cooperation in furnishing this needed information to our office.