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 499 N. El Camino Real Ste C-200 Encinitas, CA 92024
 Tel. (760) 635-7800 Fax: (760) 635-7801

Date: _____

Account #: _____ MD#: _____

PATIENT REGISTRATION FORM (New Update)

Your email: _____ Your Pharmacy: _____ (Name/Telephone Number)

PLEASE FILL OUT COMPLETELY. FAILURE TO DO SO MAY DELAY PAYMENT OF YOUR CLAIM. INDICATE N/A IF NOT APPLICABLE.

HAVE YOU EVER BEEN SEEN IN THE OFFICE BEFORE yes no if yes: Date: _____ Dr. _____

PATIENT'S FULL NAME _____ SEX M ___ F ___ Home # _____ Cell # _____
ADDRESS _____
Street City State Zip
BIRTHDATE _____ **AGE** _____ **DRIVER'S LICENSE #** _____ **MARITAL STATUS** _____
S.S. # _____ **DATE OF INJURY** _____ **JOB () AUTO () OTHER ()**
EMPLOYER _____ **OCCUPATION** _____ **Work Phone #** _____
EMPLOYER ADDRESS _____
Street City State Zip

Race _____ **Ethnicity** _____ **Language:** _____
RESPONSIBLE PARTY Name _____ Home Phone# _____ Work Phone # _____
 Relationship to Patient: Self Spouse Parent Brother Sister Son Daughter Other _____

Address _____
Street City State Zip
Employer _____ **Work Phone #** _____
EMERGENCY CONTACT Name _____ Home Phone # _____ Work Phone # _____

Referred by (check one) Family Friend Insurance **Physician** _____ Other _____
Name/Telephone Number

PRIMARY INSURANCE. CASH MEDICARE MEDI-CAL PPO HMO WORKCOMP IME/AME AUTO
CARRIER _____
CO-PAY _____ **I.D. #** _____ **Group #** _____
Insurance Address _____ **Phone #** _____
Street City State Zip
Policy Holder S.S. # of Insured _____
Insured's Address _____
Street City State Zip
Employer of Insured _____ **Work Phone #** _____

SECONDARY INSURANCE
CARRIER _____
CO-PAY _____ **I.D. #** _____ **Group #** _____
Insurance Address _____ **Phone #** _____
Street City State Zip
Policy Holder S.S. # of Insured _____
Insured's Address _____
Street City State Zip
Employer of Insured _____ **Work Phone #** _____

I hereby assign all benefits directly to OASIS MD Providers and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices.

I understand that even if a patient carries medical insurance, 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. I accept financial responsibility for all charges incurred and hereby promise to pay all charges promptly, including those not paid by my insurance. If my account has to be referred to outside collection I will be charged a service charge to cover the additional collection costs.

I also authorize OASIS MD to request and review my medications history from my pharmacy to facilitate pharmacy orders and refills.

I certify that all of the information provided herein is true and correct.

X _____
 Signature of Patient (or legal guardian if patient is a minor) _____ Date _____